

**For information
on 25 April 2017**

Legislative Council Panel on Health Services

Review on Mental Health

PURPOSE

————— This paper informs Members of the findings of the Review on Mental Health and encloses at **Annex** the Report of the Review Committee on Mental Health (the Review Committee).

BACKGROUND

2. To ensure that our mental health regime can rise up to the challenges of a growing and ageing population, the Food and Health Bureau (FHB) embarked on a review of the mental health policy and services through the setting up of the Review Committee in May 2013. Chaired by the Secretary for Food and Health, the Review Committee comprises members with wide representation, including legislative councillors, academics, healthcare professionals, service providers, service users and caregivers, representatives from the Equal Opportunities Commission, the Hong Kong Council of Social Service and the Hospital Authority (HA), as well as representatives from relevant Government bureaux/departments/organisations, including the Food and Health Bureau, the Labour and Welfare Bureau, the Education Bureau and the Social Welfare Department. The Review Committee studied the existing policy on mental health services and considered means and measures to strengthen the provision of mental health services having regard to changing needs of the community.

THE REVIEW

3. Since its establishment, the Review Committee has met nine times. It has also convened two consultative forums attended by a total of over 40 organisations including service providers, concern groups,

professional groups, patient groups and carer groups to gauge their views on existing mental health services.

4. The Review Committee adopted a life-course approach to the review, with its focus placed on the following five topics –

- (a) Mental Health Promotion
- (b) Mental Health Services for Children and Adolescents
- (c) Mental Health Services for Adults
- (d) Dementia Support Services for the Elderly
- (e) Applicability and Practicability of Introducing Community Treatment Order (CTO) in Hong Kong

After studying the existing mental health policy and services in detail, the Review Committee has put forward a total of 40 recommendations for the enhancement of the overall mental health services in Hong Kong in the following 20 areas –

Promotion and Education

- (i) To develop a long-term strategy for mental health promotion.

Research and Studies

- (ii) To conduct regular studies and encourage development of evidence-based intervention programmes.

Capacity Building

- (iii) To enhance the capacity of multi-disciplinary and primary care professionals in handling mental health cases.

Support to Children and Adolescents and their Families

- (iv) To strengthen services and manpower and provide more targeted support.
- (v) To enhance cross-sectoral and multi-disciplinary coordination.
- (vi) To adopt multi-disciplinary intervention approach to strengthen support at school.
- (vii) To provide smooth service transition at different stages.

Mental Health Services for Adults

- (viii) To enhance “Case Management Programme” for severe mental illness (SMI) cases and “Early Assessment Service for Young People with Early Psychosis” (EASY) programme.
- (ix) To enhance common mental disorder (CMD) services and explore feasibility of public-private partnership (PPP).
- (x) To strengthen manpower of Siu Lam Hospital with a view to clearing up the waitlist.

Dementia Support Services for the Elderly

- (xi) To develop a common reference for primary care professionals and explore the feasibility of PPP.
- (xii) To develop dementia-friendly neighbourhood and strengthen social care infrastructure.
- (xiii) To enhance medical-social collaboration and community support.
- (xiv) To promote end-of-life palliative care in the community setting.
- (xv) To enhance support to carers.

Alternatives to CTO

- (xvi) To review existing “conditional discharge” mechanism under the Mental Health Ordinance.
- (xvii) To strengthen community support for patients with SMI.
- (xviii) To re-visit the applicability of CTO when needs arise.

Application of Innovative Technology

- (xix) To promote the use of innovative technology to facilitate the delivery of mental health services.

Establishment of a Standing Advisory Committee

- (xx) To set up a standing advisory committee.

The Executive Summary of the report at Annex summarises the findings and recommendations of the Review Committee.

5. Based on the preliminary recommendations of the Review Committee, the Government has already introduced a number of measures, including –

- (a) the launching of a three-year territory-wide promotional campaign on mental health titled Joyful@HK;
- (b) the implementation of the Student Mental Health Support Scheme;
- (c) the widening of the scope of the “Learning Support Grant” provided to schools to cover students with mental illness;
- (d) the expansion of the Case Management Programme for patients with SMI territory-wide;
- (e) the development of a “Service Framework on Personalised Care for Adults with Severe Mental Illness in Hong Kong” to enhance the medical-social collaboration in the delivery of services for patients with SMI in the community;
- (f) the introduction of enhanced CMD clinics in the Kowloon West Cluster and expansion to other clusters by phases;
- (g) the addition of 20 mentally handicapped infirmary beds at the Siu Lam Hospital; and
- (h) the implementation of the Dementia Community Support Scheme.

Compared to 2011-12, the Government budget on mental health services provided for HA increased from around \$3.4 billion to around \$4.7 billion in 2016-17, representing an increase of almost 40% in five years, and its manpower for psychiatric services also increased by about 15%. In the same period, the Government’s expenditure on Integrated Community Centre for Mental Wellness services for ex-mentally ill persons increased by almost 90% from around \$160 million to \$303 million.

WAY FORWARD

6. In order to monitor the implementation of the recommendations of the Review Committee and to follow up on mental health development in Hong Kong, the Chief Executive announced in the 2017 Policy Address the establishment of a standing advisory committee. We will prepare for the set up of the Advisory Committee on Mental Health

in the 2nd quarter of 2017.

ADVICE SOUGHT

7. Members are invited to note the content of the paper and the Report on the Review on Mental Health.

Food and Health Bureau
April 2017



MENTAL HEALTH REVIEW REPORT



Mental Health Policy

As stated by the World Health Organization (WHO), there is “no health without mental health”¹. The Government of the Hong Kong Special Administrative Region attaches great importance to the mental well-being of the public and recognises that mental health goes beyond medical care.

The Government adopts an integrated and multi-disciplinary approach towards mental health, including promotion, prevention, early identification, as well as timely intervention and treatment, and rehabilitation for persons in need. From self-care, primary care and community support to specialist care and institutionalised services, the Government seeks to provide comprehensive and cross-sectoral services to the public (in particular, persons with mental health needs) through engagement and support of legislative councillors, academic experts, patients and carers, healthcare, social welfare and legal professionals, and stakeholders in the community, as well as collaboration and cooperation among relevant bureaux/departments, the Hospital Authority, academic institutions and organisations/associations in the healthcare, social welfare and education sectors.

It is the Government’s policy direction to encourage community support and ambulatory services, coupled with necessary and essential institutionalised services, so as to build a mental-health friendly society, facilitating re-integration into the community.

In view of the cross-sectoral nature of mental health services, it is important for the Government to put in place high-level standing mechanism to ensure full integration and coherence of services provided to the public.

¹ World Health Organization. Mental health: strengthening our response. Fact sheet No 220.

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MESSAGE FROM DR. KO WING-MAN, BBS, JP CHAIRMAN, REVIEW COMMITTEE ON MENTAL HEALTH SECRETARY FOR FOOD AND HEALTH

With a population of 7.3 million, mental health problems are not uncommon in Hong Kong. For a high-tempo, action-packed and densely-populated city like Hong Kong, the challenges we are facing are immense and multi-faceted.

Although we have a well-established public health care system, mental health services go beyond medical care. International trend encourages community support and ambulatory services for the treatment of mental illness with a view to facilitating people in need to re-integrate into the society and assisting the elderly to age in place. We need to address people's mental health needs through collaboration amongst relevant bureaux/departments, non-governmental organisations in the healthcare and social welfare sectors, as well as other stakeholders in the community.

To further enhance the mental health services and map out the future direction of the mental health policy in Hong Kong, the Government set up the Review Committee on Mental Health (Review Committee) in May 2013. In the course of the review, relevant Government bureaux/departments and the Hospital Authority have in parallel implemented enhanced measures based on the preliminary recommendations of the Review Committee to strengthen existing services covering mental health promotion, mental health services for children and adolescents as well as adults, and the dementia support services for the elderly.

Amongst the enhanced services implemented, we are pleased to see the launch of "Joyful@HK" for mental health promotion in January 2016, the implementation of the "Student Mental Health Support Scheme" in September 2016 and the "Dementia Community Support Scheme" in February 2017. For adults, a "Case Management Programme" for patients with severe mental illness and enhanced Common Mental Disorder (CMD) clinics supported by multi-disciplinary teams for patients with CMD are already in place and will be further strengthened. The review also reaffirms the importance of strengthening community support for those recovering from mental illness, enhancing capacity of healthcare professionals at the primary care level, developing public-private

partnership, as well as providing more multi-disciplinary support in the community as the long-term strategy in the development of mental health policy.

The review could not have been carried out without the support and participation of various concerned parties. We would like to take this opportunity to express our heartfelt gratitude to all members of the Review Committee, the Expert Group on Child and Adolescent Mental Health Services, the Expert Group on Dementia and the Advisory Group on Mental Health Promotion for their advice and insights on the mental health review. We would also like to thank professionals from the medical and social welfare sectors, representatives of the non-governmental organisations and concerned groups, stakeholders in the community, as well as colleagues of the Hospital Authority and our partners in the Government, including the Labour and Welfare Bureau, the Education Bureau, the Social Welfare Department, the Department of Health, the Housing Department and the Hong Kong Police Force, for their professional and valuable inputs to the review.

The conclusion of the review does not mean the end of our work but the beginning of further enhancement of our mental health services. To keep our mental health services robust and sustainable in face of the changing service needs, the Government will set up a standing advisory committee to continue to monitor the implementation of the recommendations of the review and to follow up on mental health development in Hong Kong.

It takes time, patience and continuing investment to build up our readiness and resilience of responding to the evolving needs over mental health and mental well-being. Without doubt, the inspiring thoughts delivered by the mental health review will pave the way for the long-term development of the mental health policy in Hong Kong.

Dr. KO Wing-man, BBS, JP
Chairman, Review Committee on Mental Health
Secretary for Food and Health
March 2017

EXECUTIVE SUMMARY

PART ONE: OVERVIEW

Background

The Government of the Hong Kong Special Administrative Region attaches great importance to the mental well-being of the public. It adopts an integrated approach in the promotion of mental health through a service delivery model that covers prevention, early identification, timely intervention and treatment, and rehabilitation for persons in need. From promoting self-care, primary care and community support to offering specialist care and institutionalised services, the Government seeks to provide comprehensive, multi-disciplinary and cross-sectoral services to persons with mental health needs through collaboration and cooperation among the Food and Health Bureau (FHB), the Hospital Authority (HA), the Labour and Welfare Bureau (LWB), the Education Bureau (EDB), the Social Welfare Department (SWD), the Department of Health (DH), non-governmental organisations (NGOs) and other stakeholders in the community.

Review Committee on Mental Health

2. In Hong Kong, as in other similarly developed countries or regions, mental health occupies a very prominent position on the current health care agenda. For a cosmopolitan city like Hong Kong, many people are living with different degrees of stress. Without proper management of such stress, mental health concerns that require medical and clinical attention may arise.

3. According to the Hong Kong Mental Morbidity Survey 2010-2013², the prevalence of common mental disorders among Chinese adults aged between 16 and 75 was 13.3%. The most common disorders were mixed anxiety and depressive disorder (6.9%), followed by generalised anxiety disorder (4.2%), depressive episode (2.9%), and other anxiety disorders including panic disorders, all phobias and obsessive compulsive disorder (1.5%). According to another survey conducted in 2014, 4.8% of the general public aged between 18 and 64

² Lam LC, Wong CS, Wang MJ, et al. (2015). Prevalence, psychosocial correlates and service utilisation of depressive and anxiety disorders in Hong Kong: the Hong Kong Mental Morbidity Survey. *Soc Psychiatry Psychiatr Epidemiol*. Published online first: 2015 Feb 8. DOI: 10.1007/s00127-015-1014-5.

could be classified as having severe non-specific psychological distress³. On the other hand, it is also notable that the demand for HA's psychiatric services has been on the rise in recent years, with the number of patients with mental illness under its care rising from about 187 000 in 2011-12 to over 220 000 in 2015-16.

4. Mental health problem of children and adolescents warrants our particular attention. A local study⁴ conducted in 2008 presented the respective prevalence estimates of anxiety disorders (6.9%), oppositional defiant disorder (6.8%), Attention Deficit/Hyperactivity Disorder (AD/HD) (3.9%), conduct disorder (1.7%), depressive disorders (1.3%), and substance use disorders (1.1%) among high school adolescents. The early stage of life presents an important opportunity to promote mental health and prevent mental disorders as up to half of mental disorders in adults surface before the age of 14.

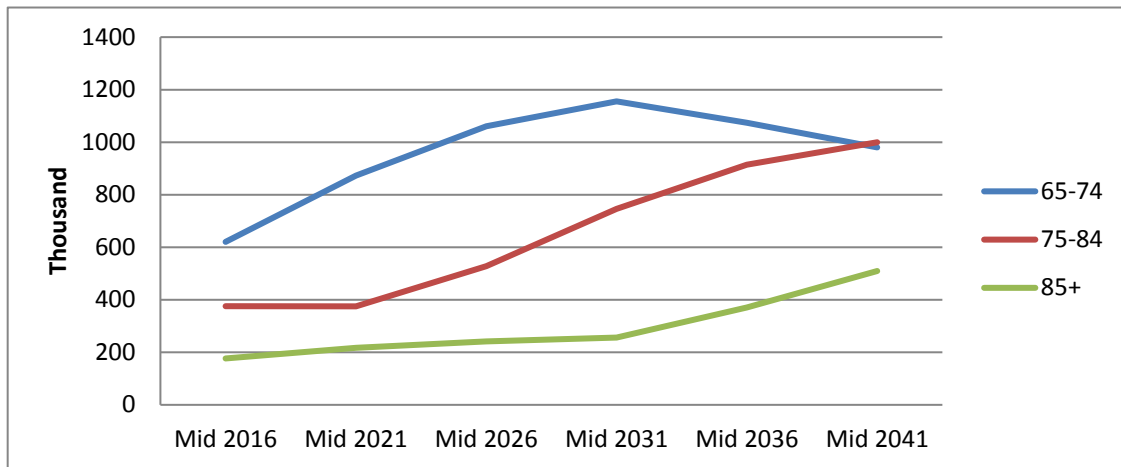
5. Apart from the increasing trend of the prevalence rate of people suffering from mental illness, the ageing population also draws concerns in the mental health service as it is projected that about one-third of the population will be aged 65 or above by 2041 (Figure 1). Dementia is a syndrome that most commonly affects older people. According to different estimates, the prevalence of dementia doubles with every five-year increment in age after 65. Over the years, there have been various studies conducted by academics and service providers attempting to scope the problem of dementia in Hong Kong, with the gloomiest estimates putting our demented population at 100 000⁵, representing almost one-tenth of the elderly population.

³ Department of Health (2015). *Behavioural Risk Factor Survey (April 2014)*. Hong Kong: Department of Health.

⁴ Leung PWL, Hung SF, Ho TP, et al. (2008). Prevalence of DSM-IV disorders in Chinese adolescents and the effects of an impairment criterion: a pilot community study in Hong Kong. *Eur Child Adolesc Psychiatry*. 2008 Oct;17(7):452-461.

⁵ In Hong Kong, some population-based research (e.g. Challenges of Population Ageing on Disease Trends and Burden conducted by the Chinese University of Hong Kong (CUHK) and the University of Hong Kong in 2010 and Trends in Prevalence and Mortality of Dementia in Elderly Hong Kong Population: Projections, Disease Burden, and Implications for Long-Term Care conducted by the CUHK in 2012) put estimates of our demented population at around 100 000.

**Figure 1 Growing Trend of Hong Kong's Aged Population
(Mid-2016 to Mid-2041)**



Source: Hong Kong Census and Statistics Department

6. To ensure that our mental health regime can rise up to the challenges of a growing and ageing population, FHB embarked on a review of the existing mental health policy and services through the setting up of a Review Committee on Mental Health (the Review Committee) in May 2013. Chaired by the Secretary for Food and Health, the Review Committee comprises some 20 members with wide representation, including legislative councillors, academics, healthcare professionals, service providers, service users and caregivers, as well as representatives from the Equal Opportunities Commission and the Hong Kong Council of Social Service (Membership list at [Annex A](#)). The Review Committee is tasked to study the existing policy on mental health with a view to mapping out the future direction for development of mental health services in Hong Kong. It also considers means and measures to strengthen the provision of mental health services in Hong Kong having regard to the changing needs of the community and resource availability. On the supply of relevant healthcare professionals, the Review Committee notes that a review on healthcare manpower is being conducted by the Steering Committee on Strategic Review on Healthcare Manpower Planning and Professional Development and would defer to the aforesaid Steering Committee to advise on issues relating to healthcare manpower.

7. The Review Committee has focused its review on the following five areas –

- Mental Health Promotion
- Mental Health Services for Children and Adolescents
- Mental Health Services for Adults
- Dementia Support Services for the Elderly
- Applicability and Practicability of Introducing Community Treatment Order (CTO) in Hong Kong

8. The Review Committee adopted a life-course approach to the review. Three subgroups, namely the Advisory Group on Mental Health Promotion, the Expert Group on Child and Adolescent Mental Health Services and the Expert Group on Dementia, were set up under the Review Committee to develop more focused and in-depth studies on the respective concerned subjects.

9. The Review Committee had met nine times since May 2013. Two consultative forums were conducted in June 2013 to gauge views of stakeholders on the existing mental health services. Over 40 organisations including service providers, concern groups, professional groups, patient groups and carer groups attended the forums.

10. In the course of the mental health review, relevant bureaux/departments and HA have been working on various initiatives in parallel based on the recommendations of the Review Committee. While some of the enhanced services and measures have already been implemented and incorporated into existing services, there are also pilot schemes⁶ formulated based on the recommendations of the Review Committee with a view to strengthening the existing mental health services.

Community and Multi-disciplinary Support in Mental Health Services

11. In reviewing the mental health services, the Review Committee considers that apart from medical services, community and multi-disciplinary support is equally important for persons with mental health needs. With

⁶ Including two 2-year pilot schemes named “Student Mental Health Support Scheme” and “Dementia Community Support Scheme” which were launched in September 2016 and February 2017 respectively.

heightened public awareness on mental health, more people in need would seek help, resulting in higher expectation for more effective and timely mental health services. Providing community support to persons with mental health needs in order to assist them to re-integrate into our society is gaining momentum. Relying solely on the specialist services to handle the increasing number of mental health cases would continue to impose heavy burden on the workload of the specialists and unavoidably affect the quality of the mental health services, in terms of the time and depth the specialists could devote to each individual.

12. Making reference to the overseas trend of making use of resources in the community to handle the bulk of mental health cases, the Review Committee considers that in the long run, having medical care plans, in particular of those stable, non-acute and less severe cases, executed in the community should become the direction for the delivery of mental health services. To effectively deliver community support services to those with mental health needs, there is also a need to enhance the capacity of relevant healthcare and social care professionals such as nurses, occupational therapists, physiotherapists, social workers, teachers, etc. to provide multi-disciplinary support in the community. The Community Geriatric Assessment Teams (CGATs)⁷ and the Case Management Programme of the HA which provide maintenance and care services for patients outside the hospital setting demonstrate as good examples of community support services. To further enhance the interface among medical, social and education services, the Review Committee recommends the strengthening of community support in respective subject areas under review so that persons with mental health needs and their carers would be supported in a more holistic manner.

13. The mental health review brings about new ideas on how best to enhance the existing services through more effective use of resources and multi-disciplinary manpower in the community to deliver the mental health services. It also gives comprehensive views on respective aspects of the mental health services that need enhancement to better address the needs of the patients and their carers as a whole. On the overall direction of the review, the Review Committee notes and reaffirms the established policy of the Government in promoting mental health to the general public and providing quality, affordable

⁷ Through regular visits to Residential Care Homes for the Elderly, CGATs provide comprehensive multi-disciplinary services (including assessment and care management) and community based rehabilitation programmes to the residents, as well as carer training to enhance the quality and continuity of care in the community.

and accessible mental health services to persons in need. Guided by this policy, the Review Committee has examined the existing service delivery models, identified service gaps and recommended measures for improvement.

14. The ensuing paragraphs summarise the work of the Review Committee.

PART TWO: AREAS UNDER REVIEW

Chapter 1 – Mental Health Promotion

15. The World Health Organization (WHO) states that there is “no health without mental health”. Mental health does not only affect personal development. In fact, family harmony, social stability and economic prosperity also hinge much on the mental well-being of individuals and the population as a whole. Therefore, good mental health of the general public is a valuable asset to our society. While it is essential to have such post-diagnosed services to facilitate recovery of patients, it is equally important to implement preventive measures to prevent or minimise the risk of onset of mental disorders in the first place. As a preventive measure, mental health promotion could help increase public awareness and understanding of mental health, promote healthy lifestyle and mental well-being, reduce stigma and encourage people in need to timely seek help. There are studies showing that effective mental health promotion demonstrates improved outcomes not only to the general public but also to people with mental health needs. Therefore, promoting mental health and well-being is an integral part of improving the overall health of the general public.

16. In Hong Kong, DH undertakes a role in health promotion and has been promoting mental well-being by enhancing public awareness through education and publicity using a life-course and setting-based approach. DH has been conducting health education and publicity to promote mental health for different target groups through production of health educational resources such as leaflets, booklets, exhibition boards, videos, websites and hotline information; organisation of health talks, workshops, programmes and outreach activities; and delivery of media publicity such as TV and radio programmes. Mental well-being is among the health issues being promoted through reference frameworks published by the Primary Care Office of DH.

17. Making reference to DH’s work in the promotion of mental health and mental well-being, the Review Committee considers it necessary to review the existing mental health promotion strategy of the Government to meet the changing needs and environment of our society. In June 2015, the Review Committee set up the Advisory Group on Mental Health Promotion (the Advisory Group), which is chaired by the Under Secretary for Food and Health and vice-chaired by the Director of Health, to oversee the planning,

implementation and evaluation of the public education and promotion campaign on mental health.

18. The Advisory Group devised a plan for the Mental Health Promotion Campaign (the Campaign). A three-year territory-wide Campaign, named Joyful@HK (好心情@HK) was launched in January 2016 (Figure 2). The Campaign, targeting at general public of all age groups, aims to (a) increase public engagement in promoting mental well-being; and (b) increase public knowledge and understanding about mental health. It promotes mental health through mass media and the organisation of various publicity activities in the community.

Figure 2 Logo of Joyful@HK



19. In order to increase public engagement in promoting mental well-being, public engagements are promoted under three main themes: “Sharing”, “Mind” and “Enjoyment” (SME) (Figure 3). Taking into account the local prevalence and the resources for the Campaign, one common mental health problem is selected for each age group, namely anxiety disorders for adolescents, mixed anxiety and depressive disorder for adults, and dementia for the elderly. It is hoped that through increased public understanding and enhanced knowledge, stigma against patients with mental illness will be minimised and mental health problems would be detected as early as possible.

Figure 3 Main themes on “Sharing”, “Mind” and “Enjoyment”



- “S - Sharing”: Sharing with family and friends and offering support to the needy.
- “M - Mind”: Keeping an open mind, perceiving things with a positive attitude and optimism.
- “E - Enjoyment”: Engaging in enjoyable activities to maximise potential and achieve satisfaction.

20. As shown in Figure 4, apart from mass media advertising and publicity activities, one of the key strategies of the Campaign is to engage stakeholders such as local people and various sectors to develop promotion programmes and activities. Making use of the existing community resources and established network, the Campaign has successfully solicited community support and increased public engagement in the promotion of mental health. Since the launch of the Campaign, a series of promotional programmes and activities have been organised or are under planning. Evaluation report with recommendations on the way forward will be provided at the end of the Campaign to facilitate the Government to formulate the long-term strategy for the mental health promotion.

Figure 4 Components of Joyful@HK



Chapter 2 - Mental Health Services for Children and Adolescents

21. The Expert Group on Child and Adolescent Mental Health Services (referring to “C&A Expert Group”) is tasked to review the existing mental health services for children and adolescents and make recommendations to the Review Committee on how to enhance the relevant services. Since the establishment of the C&A Expert Group in December 2013, it has met nine times to review the existing services and discuss the future direction for service enhancement. Apart from regular meetings, the C&A Expert Group arranged two sharing sessions with overseas experts to gauge their views on overseas experiences in implementing programmes for enhancing child and adolescent mental health services. The C&A Expert Group also met with family members and representatives from the concerned groups to listen to their concerns on existing service gaps. After rounds of discussions on the existing services, the C&A Expert Group has concluded its review which is summarised in the ensuing paragraphs.

Existing Situation in Hong Kong

22. In Hong Kong, the public system faces a growing number of children and adolescents diagnosed with mental health problems. As one indication, the caseload of the child and adolescent psychiatric teams of the HA rose from 18 900 in 2011-12 to 28 800 in 2015-16, representing an increase by more than 50% in five years.

23. The Government, including FHB, LWB, DH, SWD, EDB and HA, adopts a multi-disciplinary and cross-sectoral approach in the provision of support and care for children and adolescents with mental health problems. The existing services are multi-faceted with referral mechanism to facilitate follow-up services and treatment subject to the needs of children and adolescents (as well as their families). There are also programmes, initiatives and pilot schemes⁸ put in place to support prevention and early identification, child assessment, medical intervention, education services, social rehabilitation services and community support services. The services provided by the

⁸ A two-year “Pilot Scheme on On-site Pre-school Rehabilitation Services” launched in November 2015; a Community Care Fund (CCF) programme on “Training Subsidy Programme for Children on the Waiting List of Subvented Pre-school Rehabilitation Services” regularised in October 2014; a CCF funded three-year Pilot Project on Special Educational Needs Coordinators launched in 2015-16 school year, etc.

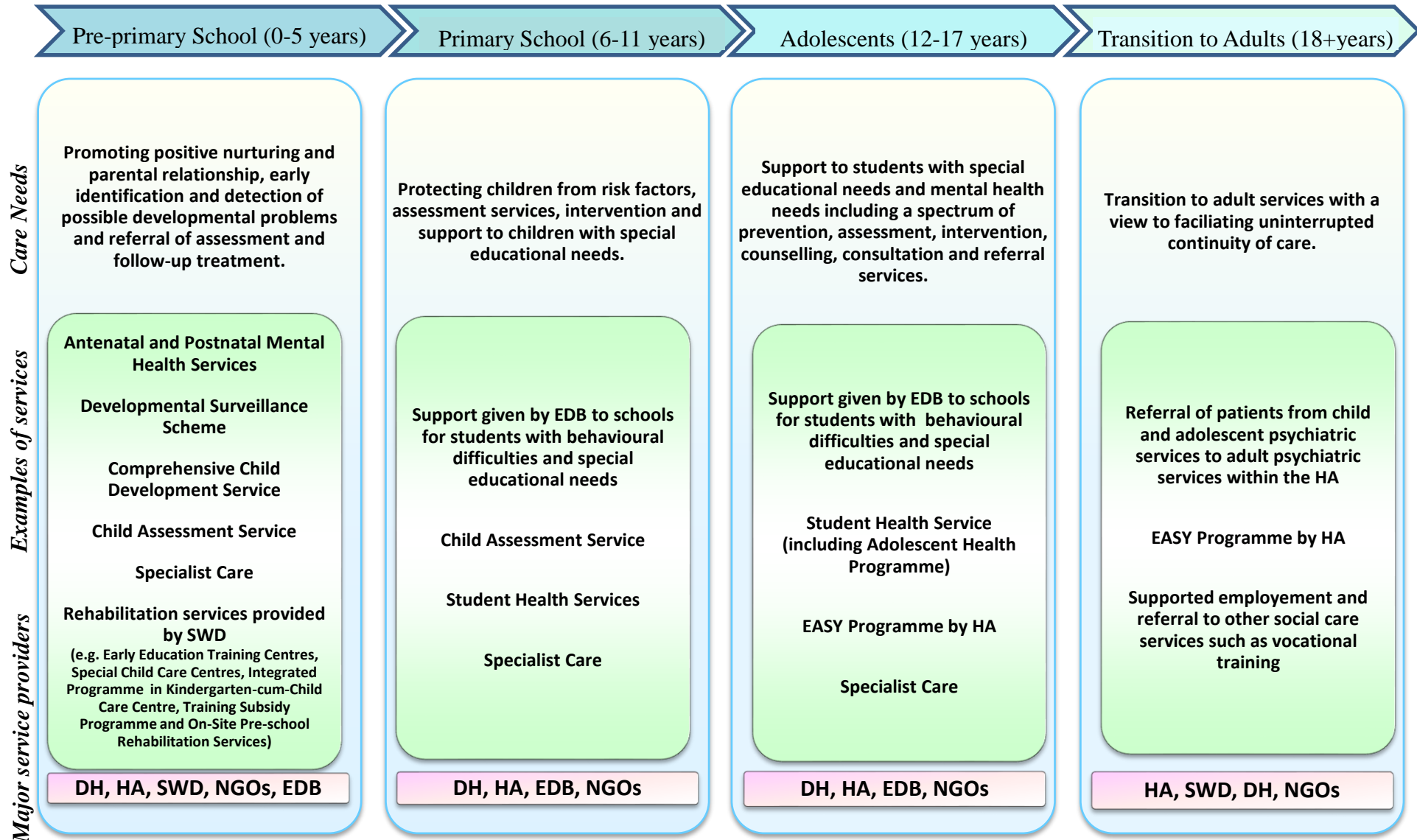
respective service providers for children and adolescents of different age ranges are summarised in Figure 5.

Service Gaps

24. The Government endeavors to provide a comprehensive range of services to support children and adolescents with mental health problems. Yet the existing services are not free of gaps because the complexity of the problems straddle multiple disciplines and sectors. Along the care pathway, the C&A Expert Group has identified the needs to enhance coordination and continuity of services from one stage to another to ensure a smoother transition from pre-school age to school age and from adolescence to adulthood, as well as to improve the coordination among various service boundaries.

25. The C&A Expert Group sees the need to refine the service delivery model to make it more responsive to the needs of children and adolescents, with a view to providing more integrated support and improving waiting time for services. The C&A Expert Group also considers it important to strengthen the support to parents and teachers for the enhancement of emotional well-being of children and adolescents in collaboration with other professionals in schools and the community.

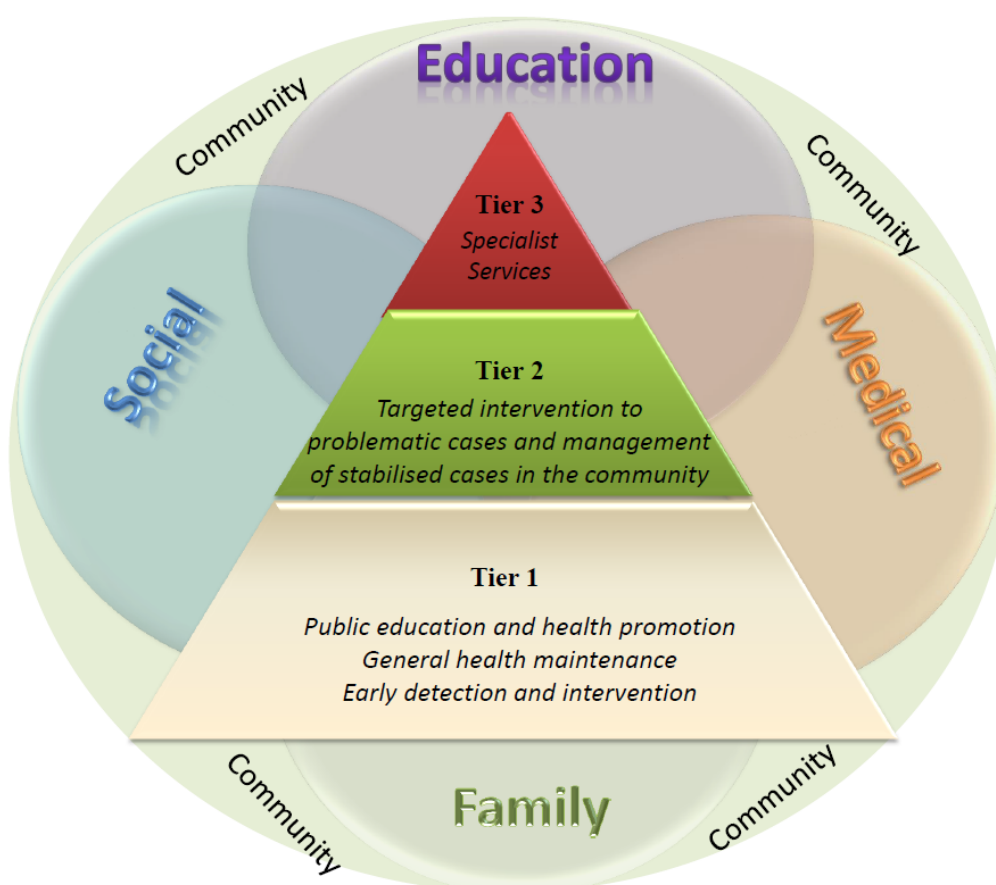
Figure 5 Support for Children and Adolescents with Mental Health Needs



Three-Tier Stepped Care Model for Children and Adolescents with Mental Health Needs

26. The C&A Expert Group recommends the adoption of a three-tier stepped care model as illustrated in Figure 6 to facilitate cross-sectoral and multi-disciplinary collaboration in the delivery of child and adolescent mental health services. For the three-tier model to function effectively, the C&A Expert Group considers it necessary to enhance the coordination among tiers.

Figure 6 Three-Tier Stepped Care Model

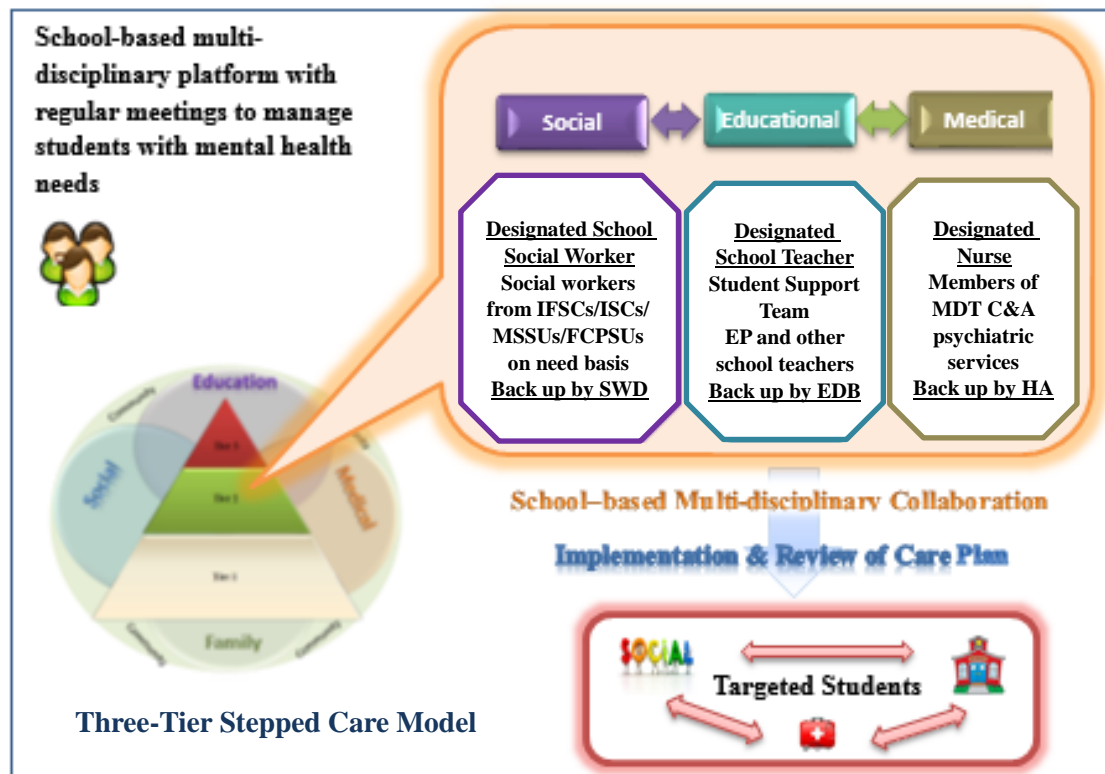


27. Tier-1 services refer to universal prevention, early detection and intervention as well as mental health maintenance that are accessible by children, adolescents and their families in their everyday life through public education, parenting programmes, promotional activities in the community or at schools, etc. Tier 2 is to serve as a bridge between Tier 1 and Tier 3 to provide more structured and targeted assessment and intervention to children and adolescents in need. Tier 3 provides specialist intervention to moderate to severe mental

health cases. While services at Tier 1 and Tier 3 are relatively well established, the Review Committee sees the need to enhance the services in Tier 2 in order to avoid premature escalation of cases to Tier 3 and to properly manage and support the cases in Tier 2, with an ultimate goal to return cases to Tier 1.

28. Based on the recommendation of the C&A Expert Group, a two-year pilot scheme, named “Student Mental Health Support Scheme”, was launched in 17 primary and secondary schools in the 2016-17 school year in two phases with a view to stepping up the support services in Tier 2 through a medical-educational-social collaboration model (Figure 7). Under the pilot scheme steered by FHB in collaboration with HA, EDB and SWD, a school-based multi-disciplinary communication platform involving healthcare, education and social care professionals in each participating school is set up to coordinate and provide support services to students and their families in need. This new service delivery model will help test the effectiveness in extending the support to students with mental health needs in the school setting and provides a good reference to the Government in developing more targeted and effective services for students in need in the community.

Figure 7 Student Mental Health Support Scheme on Medical-Educational-Social Service Delivery Model



29. Apart from the need to strengthen the support in each tier of the stepped care model, the C&A Expert Group also considers that the existing services, while not lacking in terms of breadth and coverage, should be consolidated and strengthened through better coordination and/or integration of services, joint capacity building for professionals of different sectors and disciplines, and closer collaboration with parents and the wider community. In conclusion, the C&A Expert Group has proposed a total of 20 recommendations (details in Chapter 2) for the enhancement of the child and adolescent mental health services.

Chapter 3 - Mental Health Services for Adults

30. For adult psychiatric services, the Review Committee has identified three areas, namely services for severe mental illness (SMI), common mental disorder (CMD) and learning disability, for service enhancement having regard to the changing needs of the community and resource availability. In the course of the review, service enhancements based on the recommendations of the Review Committee are being planned or have been implemented. The progress of the review was reported to the Legislative Council Panel on Health Services in April 2014. The latest development of the enhanced services are summarised in the ensuing paragraphs.

Existing Situation in Hong Kong

31. HA has been adopting an integrated and multi-disciplinary approach in delivering psychiatric services to support patients with mental health problems. The multi-disciplinary psychiatric teams of HA comprising healthcare practitioners in various disciplines, involving doctors, psychiatric nurses, clinical psychologists, occupational therapists and medical social workers, etc., provide comprehensive and continuous medical support to psychiatric patients, including in-patient care, specialist out-patient (SOP) service, day training and community support services. HA also provides community support to psychiatric patients through collaboration and cooperation with SWD, NGOs and other stakeholders in the community. In social welfare sector, a range of social rehabilitation services, including community support, vocational rehabilitation and residential care are provided for patients with mental health problems. Besides, the Integrated Community

Centres for Mental Wellness (ICCMWs) across the territory provide one-stop and district-based community support services, including casework counselling, outreaching visits, therapeutic and supportive groups, day training, occupational therapy training, public education programmes, etc. to ex-mentally ill persons, persons with suspected mental health problems, their families/carers and residents living in the serving district.

32. HA currently takes care of nearly 150 000 patients with mental illness who are aged between 18 and 64. Amongst which, about 30% are patients with SMI and about 60% are with CMD. Patients with severe or complex mental health needs are provided with multi-disciplinary and intensive specialist care in appropriate hospital settings, whereas those less complex cases including persons with CMD will receive specialist-supported care in the community including primary care settings. In planning its adult mental health services, HA places special emphasis on early intervention and assertive treatment, especially for those at risk of relapse and hospitalisation.

Progress Updates on Enhanced Services

Patients with SMI

33. For patients suffering from SMI, HA provides a combination of in-patient, out-patient and community psychiatric services to them depending on treatment needs. Targeted intervention is further introduced through the Early Assessment Service for Young People with Early Psychosis (EASY) programme and the Case Management Programme. Medication is improved and medical-social collaboration is also established to provide more integrated support services for patients with SMI.

34. At present, about 1 300 patients (new cases with first-episode psychosis) receive intensive care under the EASY programme each year. The Case Management Programme has been providing intensive, continuous and personalised support for patients with SMI since 2010-11. As at 31 December 2016, the Case Management Programme supported around 15 000 patients with SMI residing in the community, maintaining the case manager to patients ratio of around 1:47 on average. As regards the use of drugs, HA has taken steps to increase the use of newer psychiatric drugs with less disabling side-effects over the years and repositioned all newer generation oral anti-psychotic drugs from the special drug category to the general drug category (except Clozapine due to

its side effects) in the HA Drug Formulary so that all these drugs could be prescribed as first-line drugs.

35. In response to the rising expectation for seamless collaboration between the medical and social sectors and to achieve better community re-integration for SMI patients, HA, SWD and major NGOs operating community mental health support services set up a task group in 2014 to revisit the existing service model and published the “Service Framework on Personalised Care for Adults with Severe Mental Illness in Hong Kong” (the Service Framework)⁹ in July 2016 for enhancing collaboration and communication between the two sectors. A task force has been set up to follow up on the implementation of the Service Framework.

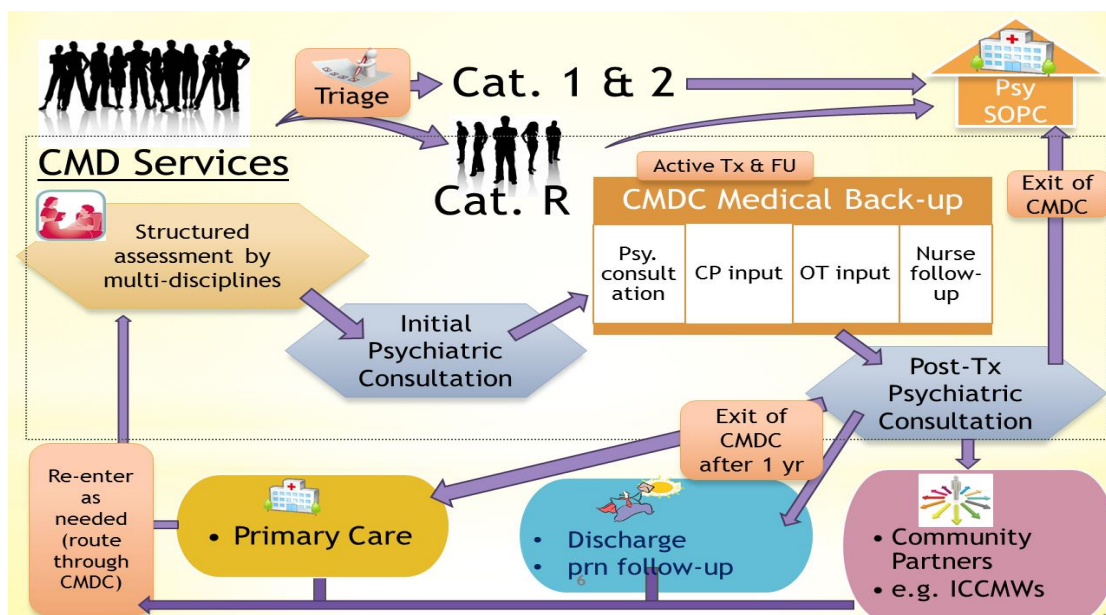
Patients with CMD

36. To enable early diagnosis and treatment of patients with CMD such as depression and anxiety disorders, HA has set up dedicated CMD clinics at its psychiatric specialist out-patient clinics (SOPCs) since 2010 for fast-tracking some 7 000 cases annually.

37. With increasing demand for mental health services and the majority of persons on waiting list at SOPCs being CMD cases, HA piloted an enhanced CMD Clinic at Kwai Chung Hospital of the Kowloon West Cluster in July 2015 (Figure 8). The pilot programme has enhanced the multi-disciplinary element in the service delivery model by engaging more psychiatric nurses and allied health professionals to provide more active and personalised psychosocial interventions for targeted CMD patients.

⁹ Full text of the “Service Framework on Personalised Care for Adults with Severe Mental Illness in Hong Kong” can be downloaded from the following website:
http://www.ha.org.hk/upload/publication_42/513.pdf

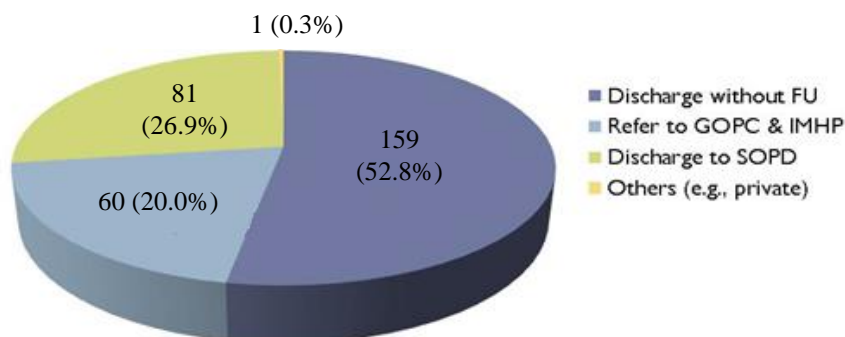
Figure 8 Service Delivery Model of Enhanced CMD Clinic



Note: Cat. 1 and 2 are categorised as Urgent Case (Priority 1) and Semi-urgent Case (Priority 2) respectively. Cat. R is categorised as Stable Case (Routine).

38. A preliminary finding revealed that more than half of the patients who completed the treatment programme provided by the enhanced CMD clinic no longer required follow-up by the psychiatric SOP service (Figure 9). In view of the effectiveness of the multi-disciplinary support in facilitating recovery of patients suffering from CMD, the enhanced CMD services have been extended to Kowloon East Cluster since July 2016 and will be further extended to the New Territories East Cluster in 2017-18.

Figure 9 CMD pilot programme - Preliminary findings



Patients with Learning Disability

39. For patients with severe and profound intellectual disability, infirmary and rehabilitation in-patient services are provided by the Siu Lam Hospital which originally operated 500 beds. The median waiting time for admission in 2015-16 is about 24 months. As at 31 March 2016, there were a total of 19 patients on the active central waiting list. Following the completion of the renovation works in Siu Lam Hospital, a new ward with additional 20 beds was opened in December 2016 to meet the service demand. It is expected that the waiting list will start to be cleared up upon the enhancement of manpower, including nursing staff and allied health professionals

Service Gaps

40. The enhanced services for adult patients are implemented in parallel to the review of the Review Committee and have registered positive outcomes since inception. Nevertheless, the Review Committee considers that there are still rooms for further improvement so that the quality of life of people suffering from mental illness could be further improved and that services required would be made more readily accessible by persons in need.

41. The Review Committee notes that the EASY programme has managed to shorten the time between onset of symptoms and interventions but due to limited resources, not all new cases with first-episode psychosis are covered under the programme at the moment. There is also a need to further improve the existing ratio of case manager to patients with SMI taking into account the intensity of the support services required by a patient with SMI.

42. On the other hand, the service delivery model run under the enhanced CMD clinic has proved to be effective in handling CMD cases but only two out of seven HA clusters are providing the enhanced services at the moment. There is a need to strengthen the multi-disciplinary teams in other clusters and expand the services to all clusters as early as possible.

43. The Review Committee points out that simply strengthening the multi-disciplinary teams is not sufficient to alleviate the bottleneck situation of the SOP service of HA. The Review Committee considers that primary care plays an important role in the maintenance of stable CMD patients. In the light of

rising demand for care of CMD patients, healthcare professionals in primary care would need to enhance its role, capacity and expertise in the long run to help manage stabilised CMD cases in the community or downloaded from HA, and hence enabling more effective and efficient use of psychiatric specialist services in HA. Training for healthcare professionals in primary care should be enhanced so that they are equipped with necessary skills and knowledge in providing care to patients with CMD. Without sharing out cases to primary care, the demands for SOP service will remain to be high and as a result continue to impose pressure on the waiting time of persons in need for such service.

44. Arising from the review of the mental health services for adults, six recommendations are proposed for enhancing the relevant services (details in Chapter 3).

Chapter 4 - Dementia Support Services for the Elderly

45. Facing the challenges of aging population and increasing service demand, the Expert Group on Dementia (referring to “Dementia Expert Group”) was set up under the Review Committee in December 2013 to review the existing dementia support services and make recommendations to the Review Committee on the enhancement of relevant services. The Dementia Expert Group had held nine meetings and met with representatives from the Hong Kong Medical Association to exchange views on enhancing the role of primary care physicians in dementia care. The review outcome of the Dementia Expert Group is summarised in the ensuing paragraphs.

Existing Situation in Hong Kong

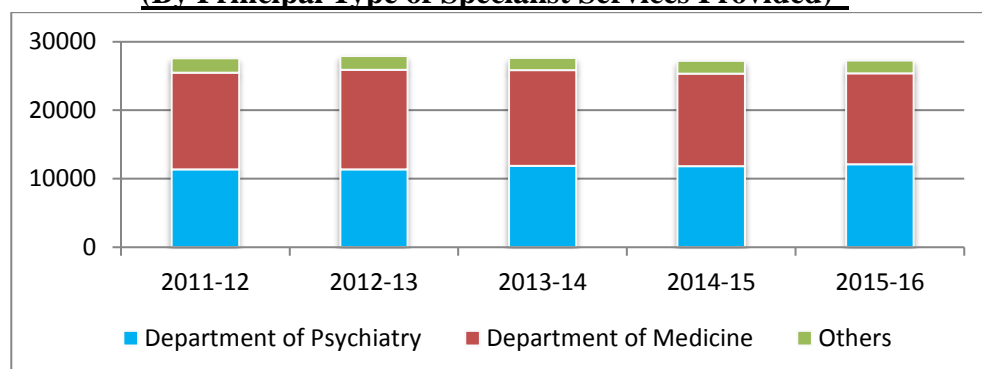
46. In Hong Kong, people aged 65 or above currently make up about 16%, or 1.2 million, of our population. By 2041, it is projected that almost one in three of our population will be aged 65 or above. Over the past years, there have been various studies conducted by academics and service providers attempting to scope the problem of dementia in Hong Kong, with the gloomiest estimate putting our demented population at 100 000¹⁰. While there is no

¹⁰ In Hong Kong, some population-based research (e.g. Challenges of Population Ageing on Disease Trends and Burden conducted by CUHK and the University of Hong Kong in 2010 and Trends in Prevalence and Mortality of Dementia in Elderly Hong Kong Population: Projections, Disease

regular survey of the demented population diagnosed by the private sector, that recorded by the public healthcare system is on the clear rise.

47. About 28 000 people with different degrees of dementia are receiving services in HA (Figure 10). Among which, more than half of these cases are persons with mild or moderate dementia. People at this stage are in transition between healthy, active life and frailty. With appropriate support, the health conditions of these people could be managed. This is precisely the time when intervention, especially at the primary care and community level, should be given to prolong the progression of their disease so that patients can stay in the community for as long as possible. It will also reduce unnecessary and premature admission to infirmaries, hospitals and residential care homes for the elderly, and in turn improve their quality of life before reaching the severe stage of dementia.

**Figure 10 Number of Persons with Dementia Receiving Care at HA
(By Principal Type of Specialist Services Provided)**



Source: HA

48. In Hong Kong, the Government adopts a multi-disciplinary and cross-sectoral approach in the provision of holistic care to people with dementia. From prevention and early detection to treatment and provision of long-term care, the Dementia Expert Group notes that FHB, LWB, HA, DH, SWD and other relevant parties including NGOs all work together to address the complex needs of people with dementia. Since 2014-15, an additional full-year recurrent funding has been provided to all 41 subvented District Elderly Community Centres (DECCs) in the territory to employ more social workers with a view to enhancing the support services for elderly persons with dementia and their carers.

Burden, and Implications for Long-Term Care conducted by the CUHK in 2012) put estimates of our demented population at around 100 000.

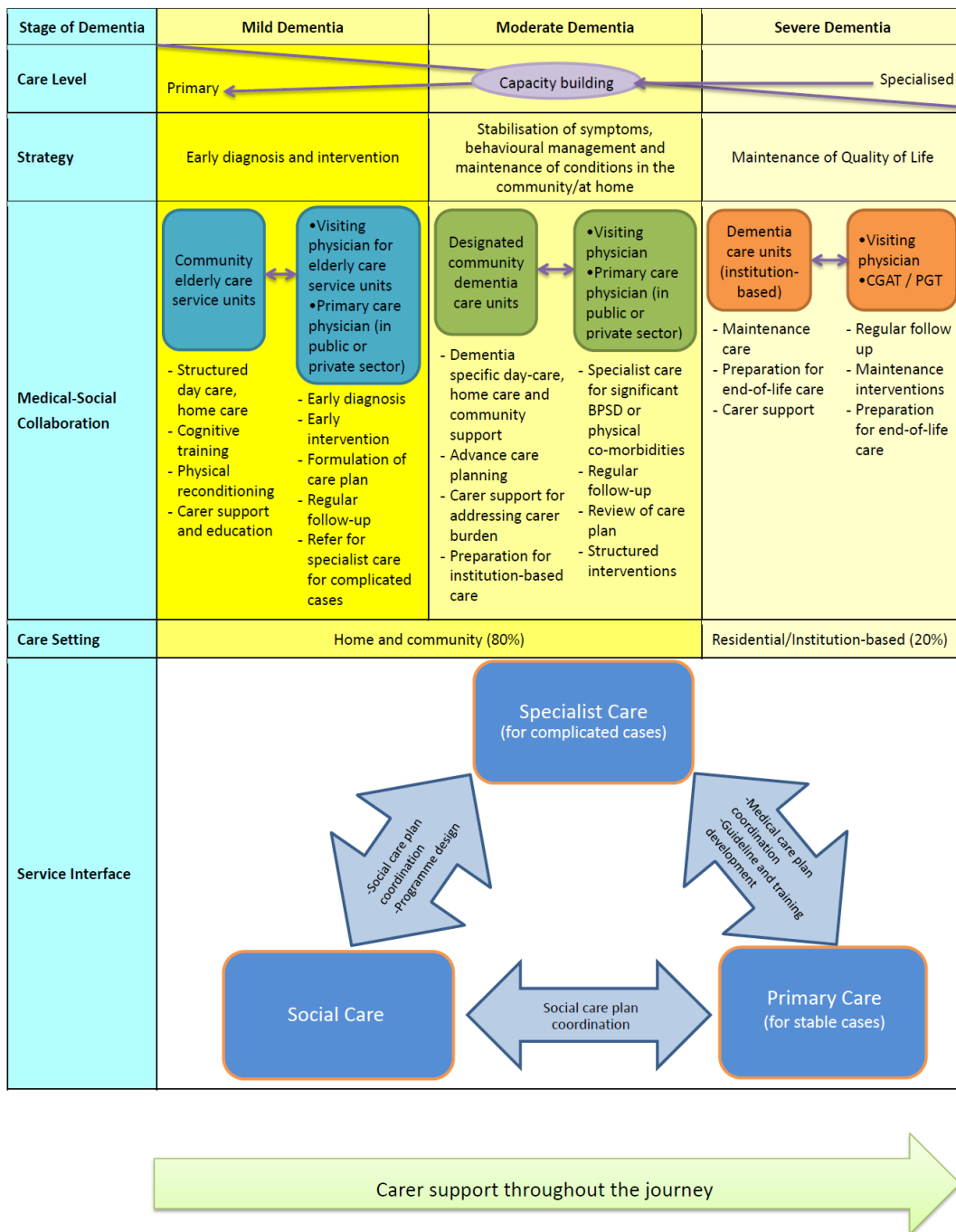
Service Gaps

49. The Government endeavours to provide a comprehensive range of services to support persons with dementia as they move through each progressive stage of the disease. Yet the existing services are not free of gaps due to the complexity of the problem which straddles multiple disciplines and sectors. Having reviewed the existing services for elderly with dementia, the Dementia Expert Group considers the need to adopt a more integrated approach in the provision of holistic and coordinated care and ensure that the delivery of services will be sustainable for an ageing population noted for its longevity.

50. With an ultimate goal of facilitating persons with dementia to age in place with dignity, the Dementia Expert Group considers it important to develop an intervention model for attending to persons with mild or moderate dementia in the primary care and community setting. Through enhancing the capacity of the healthcare and social welfare professionals in the community, stabilised cases of dementia should be managed at the community level, thereby allowing more effective use of specialist resources in the management of complicated cases. With better alignment and integration of medical and social services in the community, public and private resources and expertise could be effectively used on the dementia care and support services.

51. Taking into account the above considerations, the Dementia Expert Group derives a medical-social collaboration model (Figure 11) that illustrates the different care levels, strategies and care setting for those who are at different stages of dementia. Effective collaboration of different disciplines could reduce service gaps and avoid duplication of resources between various professions, as well as necessitate the required medical support.

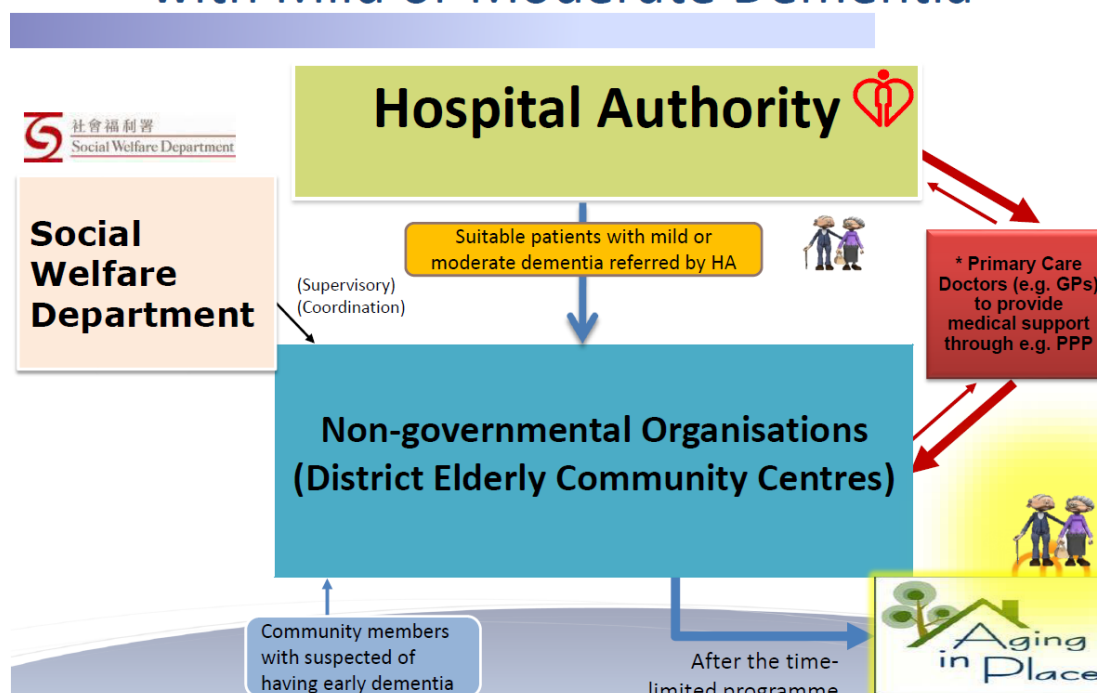
Figure 11 Medical-Social Collaboration in Dementia Care



52. With reference to the above model, a two-year pilot scheme named “Dementia Community Support Scheme” was launched in February 2017. The pilot scheme, steered by FHB in collaboration with HA and SWD, aims at providing support services to the elderly with mild or moderate dementia at the community level through a medical-social collaboration model (Figure 12). The pilot scheme involves the participation of 20 subvented DECCs out of a

total of 41 subvented DECCs in the territory and four HA clusters. Under the pilot scheme, healthcare professionals such as nurses, occupational therapists/physiotherapists as well as social welfare staff provide support to elderly persons with dementia at the participating DECCs. It is expected that about 2 000 elderly persons as well as their carers in the community will be benefited from the support services provided under the pilot scheme.

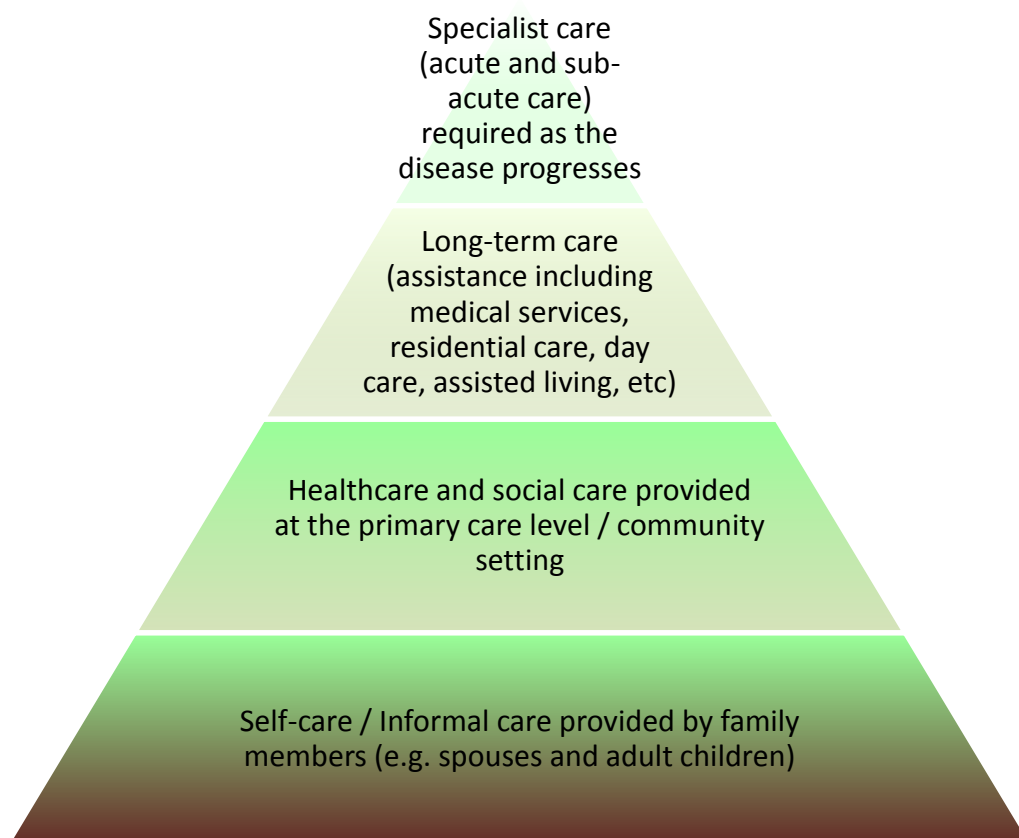
Figure 12 Dementia Community Support Scheme
Service Delivery Model for Persons
with Mild or Moderate Dementia



* HA will explore the feasibility of inviting trained general practitioners (GPs) to provide primary care support to stable patients through the public-private partnership (PPP) arrangement at a later stage of the Pilot Scheme.

53. Apart from the medical-social collaboration model of the pilot scheme for mild or moderate dementia cases, the Dementia Expert Group also notes the importance of continuous medical and social care support and services to the elderly with dementia. A coordinated cross-sectoral and multi-disciplinary approach is required to bring the best possible outcomes in its care. Figure 13 illustrates the ideal care pyramid where individuals with multiple needs at different stages of dementia would receive the appropriate level of care. The ultimate goal behind this concept is to delay the onset of dementia and slow its progression with a view to facilitating ageing in place with dignity.

Figure 13 Dementia Care Pyramid



54. For the enhancement of dementia-related services, the Dementia Expert Group has proposed ten recommendations (details in Chapter 4). The recommendations underline the Dementia Expert Group's commitment to raising public awareness of dementia and strengthening care for persons with dementia through a comprehensive array of services ranging from prevention, intervention to social support in the community.

Chapter 5 - Applicability and Practicability of Introducing Community Treatment Order (CTO) in Hong Kong

55. A CTO, or involuntary psychiatric treatment in the community, is a legal provision mandating a person with mental illness who meets specified criteria to follow a prescribed course of treatment while living in the community, non-compliance of which may cause the person to be recalled to a hospital for treatment. CTO regimes operate in a dozen or so economies, including the

United States, Canada, the United Kingdom, Australia, New Zealand, Belgium, Luxemburg, Portugal, Sweden, Norway, Israel and Taiwan. CTO comes in different names and forms, and the varying design across jurisdictions often reflects the constitutional, social and legal contexts in which the relevant legislation is enacted.

56. Following a high profile tragedy involving patient with SMI¹¹ in Hong Kong, a review committee of the HA recommended, among other things, the Administration to study further the applicability and practicability of CTO in Hong Kong. Against this background, the Review Committee has looked into the subject matter.

57. After considering all relevant factors including experience elsewhere in using CTO as a legal instrument for compelling people with mental illness to receive psychiatric treatment in the community, the Review Committee notes that the introduction of CTO is a highly sensitive and complex issue involving considerations from different perspectives. In the absence of solid evidence to prove the efficacy of CTO, the Review Committee is unable to conclude that the benefits derived from CTO will be able to compensate for the curtailment on civil liberties or that the occurrence of tragic incidents involving mentally ill patients will be reduced as a result.

58. Given the contention over the usefulness of CTO and its far-reaching implications, the Review Committee considers it prudent to further study the applicability of CTO in Hong Kong when needs arise. Meanwhile, community support should be further enhanced by strengthening the support to patients with SMI in the community under the Case Management Programme. The Review Committee also recommends that HA should review the conditional discharge provision under the Mental Health Ordinance with a view to filling the gaps in the incumbent legislation.

¹¹ A 42-year-old man chopped neighbours, a security guard and two housing estate officers, causing two deaths and three injuries at Kwai Shing East Estate on 8 May 2010. The man had a known history of mental illness. He was admitted to Kwai Chung Hospital in September 2004. After discharge, he attended SOPC regularly and was followed up by community psychiatric nurses until the occurrence of the tragic incident.

PART THREE: RECOMMENDATIONS

59. The Review Committee, having studied in details the discussions of mental health promotion, mental health services for children and adolescents, mental health services for adults, dementia services for the elderly and the applicability of CTO in Hong Kong, puts forward a total of **40 recommendations** for the enhancement of the overall mental health services in Hong Kong (details in respective chapters). In general, the recommendations cover the following **20 areas**:

Promotion and Education

1. *Long-term strategy of mental health promotion should be developed with reference to the evaluation outcome on the Mental Health Promotion Campaign and targeted public education on different mental health problems should be launched for respective age groups to promote mental well-being and foster a caring environment for people with mental illness.*

Research and Studies

2. *Epidemiological studies should be conducted on a regular basis to understand the state of mental health of the population in Hong Kong and the local prevalence of respective mental health problems with a view to facilitating service planning. Research on intervention programmes should be encouraged to enable service providers to develop evidence-based intervention programmes locally.*

Capacity Building

3. *Training on mental health should be strengthened for care professionals (e.g. school personnel, social workers, nursing staff, allied health professionals, primary care physicians, etc.) to facilitate multi-disciplinary support at the community level and in the school setting, to alleviate the demand for specialist services and to facilitate the development of PPP for trained GPs to handle stable cases downloaded from HA.*

Support to Children and Adolescents and their Families

4. *More targeted support should be provided to children and adolescents of different age groups (i.e. pre-school-aged children, school-aged children/adolescents and youth) and their families, ranging from preventive measures such as positive parenting and universal promotion of mental well-being at schools to early identification and intervention programmes through enhancement/ integration of existing services, multi-disciplinary support in the school setting, capacity building of school personnel, enhancement of manpower and other resources for assessment and medical services, as well as provision of youth-friendly platforms to facilitate detection and encourage help-seeking.*
5. *Coordination among different service units in each tier and communication of care professionals across different tiers should be enhanced so that more holistic and integrated support could be provided to the children/adolescents and their families in need under the three-tier stepped care service delivery model.*
6. *Multi-disciplinary intervention approach should be adopted to strengthen mental health support services at school. It is recommended to pilot a medical-educational-social model through collaboration of EDB, SWD and HA with a view to stepping up the tier-2 support to students and their families in need.*
7. *Support should be strengthened to ensure smooth transition of persons in need from pre-school-aged rehabilitation services to school-aged support services, and from child and adolescent mental health services to respective adult services (e.g. psychiatric services, supported employment, rehabilitation training services, etc.)*

Mental Health Services for Adults

8. *To further enhance the support for patients with SMI in the community, HA should conduct a review on the ratio of case manager to patients with SMI, enhance the peer support services under the Case Management Programme, and extend the EASY programme to cover all new cases of first episode psychosis.*
9. *For the enhancement CMD services, enhanced CMD clinic should be extended to other clusters of HA through strengthening the manpower of multi-disciplinary teams. For rolling out the PPP, service delivery model should also be worked out by HA as early as possible.*
10. *To clear up the waitlist of patients with learning disability for admission to Siu Lam Hospital, HA should enhance the manpower, including nursing staff and allied health professionals, following the opening of the new ward with additional beds in Siu Lam Hospital.*

Dementia Support Services for the Elderly

11. *A common reference should be developed to facilitate primary care professionals on diagnosis and management of dementia, and the feasibility of PPP should be explored.*
12. *Social care infrastructure should be strengthened through developing dementia-friendly neighbourhood and providing more dementia-specific services in the community to facilitate persons with dementia to remain in the community for as long as possible.*
13. *Medical-social collaboration should be enhanced and the healthcare and social care interventions should be integrated with a view to providing more patient-centred support. It is recommended to pilot a medical-social collaboration model to support the elderly with mild or moderate dementia at the community level.*
14. *End-of-life care and palliative care in the community setting should be promoted to minimise unnecessary and repeated hospitalisation.*

15. *Support for carers should be enhanced. This includes providing them with structured and accessible information, equipping them with skills to assist in caring, providing respite care services to the elderly to enable the carers to engage in other activities.*

Alternatives to CTO

16. *The existing “conditional discharge” mechanism under the Mental Health Ordinance should be reviewed in order to further safeguard the health and safety of the patient and others in the community.*
17. *HA should conduct a review on the case manager to patients ratio so as to bring about an optimal level of support to patients with SMI in the community.*
18. *The Government should monitor the review of the “conditional discharge” mechanism and the enhanced Case Management Programme, the prevalence of concrete evidence on the efficacy of CTO, as well as the public sentiment on patient management, and re-visit the applicability of CTO in Hong Kong when needs arise.*

Application of Innovative Technology

19. *In view of the trend of promoting innovation and technology in the community, applying more innovative technology in the provision of mental health services should be encouraged with a view to streamlining the labour-intensive operation of hospitals, elderly centres/homes etc., facilitating the health and social care professionals and frontline workers to perform their daily work more effectively and attracting more new blood, in particular young people, to join the workforce in the long run.*

Establishment of a Standing Advisory Committee

20. *To ensure that the mental health services in Hong Kong are sustainable in face of the rising demands for better services, the Review Committee recommends the establishment of a standing advisory committee to serve as a collaborative platform for stakeholders, patient groups, professionals, academics, representatives from relevant organisations and bureaux/departments, etc. to monitor the implementation of the recommendations of the mental health review and to give advice on further service enhancement to address the changing needs of the society, such as to look into services for patients with mental illness who are entering the elderly stage, to re-visit the applicability of CTO in Hong Kong when needs arise, etc.*

Chapter 1 - Mental Health Promotion

1.1 Introduction

1.1.1 The World Health Organization (WHO) Constitution enshrines the highest attainable standard of health as a fundamental right of every human being¹². Health, as defined by WHO, is “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”¹³. WHO states that there is “no health without mental health”¹⁴ and mental health is defined as a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make contribution to his or her community”¹⁵.

1.1.2 Mental well-being and mental illness are closely related states which can co-occur in individuals.¹⁶ The mental health status of the general public is determined by an inter-play of the two dimensions of level of mental well-being and symptoms of mental illness, and is best explained by a four-quadrant scheme (Figure 1.1). This model clearly demonstrates the absence of mental illness does not imply the presence of mental well-being. Promoting mental health and well-being will deliver improved outcomes not only to the general public but also to people with mental health problems. Good mental health is recognised as a key asset and resource for the well-being of the general public as well as for the long-term social and economic prosperity of society^{17,18,19}. In

¹² World Health Organization. (2013). The right to health. Fact sheet no. 323. Geneva: World Health Organization.

¹³ Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

¹⁴ World Health Organization. Mental health: strengthening our response. Fact sheet No 220.

¹⁵ World Health Organization. 2004. Promoting Mental Health: Concepts, Emerging Evidence, Practice. Summary Report. A report of the World Health Organization, Department of Mental Health and Substance Abuse in collaboration with the Victorian Health Promotion Foundation and the University of Melbourne. Geneva: World Health Organization.

¹⁶ Keyes, CLM. (2003). Complete mental health: An agenda for the 21st century. In Keyes CLM, Haidt, J. Flourishing: Positive Psychology and the Life Well-Lived. Washington, DC: American Psychological Association Press.

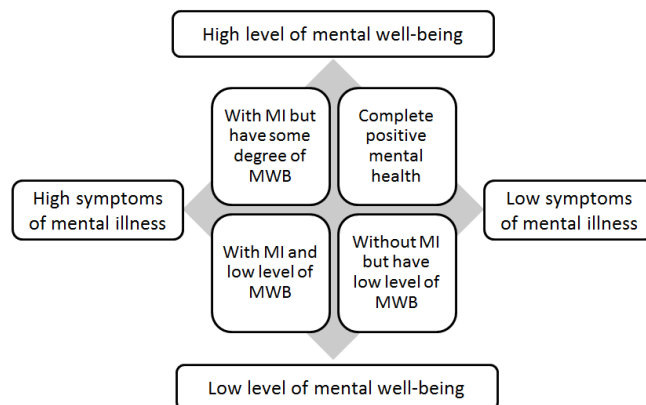
¹⁷ World Health Organization. (2002). Prevention and Promotion in Mental Health. Geneva: World Health Organization.

¹⁸ World Health Organization (2005) Mental Health Action Plan for Europe Facing the Challenges, Building Solutions. WHO.

¹⁹ Department of Health, UK (2010), ‘New Horizons - Confident Communities, Brighter Futures: a framework for developing well-being

addition, a growing body of evidence^{20, 21, 22, 23} demonstrates that the effectiveness of mental health promotion interventions can further strengthen the case for action²⁴. Therefore, promoting mental health and well-being is an integral part of improving the overall health of a population.

Figure 1.1: Two continuum model of mental health (adopted from Keyes)



1.2 Framework of Mental Health Promotion

1.2.1 Through some landmark publications by WHO, the rationale for mental health promotion and its conceptual approach to mental health improvement have become more clearly established internationally.

Principles for Promoting Mental Health

1.2.2 A health promotion framework locates mental health within a holistic definition of health and builds on the basic principles as outlined in the Ottawa

²⁰ World Health Organization. 2004. Promoting Mental Health: Concepts, Emerging Evidence, Practice. Summary Report. A report of the World Health Organization, Department of Mental Health and Substance Abuse in collaboration with the Victorian Health Promotion Foundation and the University of Melbourne. Geneva: World Health Organization.

²¹ World Health Organization. 2004. Prevention of Mental Disorders: Effective Interventions and Policy Options. Summary Report. A report of the World Health Organization Department of Mental Health and Substance Abuse in collaboration with the Prevention Research Centre of the Universities of Nijmegen and Maastricht. Geneva: WHO.

²² Jané-Llopis, E., Barry, M., Hosman, C., and Patel, V. 2005. Mental health promotion works: a review. In E. Jané-Llopis, M.M. Barry, C. Hosman and V. Patel (Eds). The evidence of mental health promotion effectiveness: strategies for action. Promotion and Education, suppl2:9-25.

²³ Keleher, H. and Armstrong, R. 2005. Evidence-based Mental Health Promotion Resource. Melbourne: Department of Human Services.

²⁴ Barry, M.M. & Friedli, L. (2008). The influence of social, demographic and physical factors on positive mental health in children, adults and older people. Foresight Mental Capital and Wellbeing Project. State-of-Science Review: SR-B3. Government Office of Science and Innovation, London, UK.

Charter (1986)²⁵, and Bangkok Charter (2005)²⁶. The principles of health promotion practice, as articulated in the Ottawa Charter, are based on an empowering, participative, and collaborative process which aims to improve health. Health promotion is the process of enabling people to increase control over, and to improve their health. The Ottawa Charter embraces a positive definition of health and shifts the focus from an individual, disease prevention approach toward the health actions and wider social determinants that keep people healthy²⁷.

WHO's Comprehensive Mental Health Action Plan

1.2.3 In 2012, the 65th World Health Assembly (WHA) adopted the resolution WHA65.4²⁸ on the global burden of mental disorders and the need of a comprehensive and coordinated response from health and social sectors at the country level. It urged Members States to develop and strengthen comprehensive policies and strategies that address the promotion of mental health, prevention of mental disorders, and early identification, care, support, treatment and recovery of persons with mental disorders. In 2013, the 66th WHA adopted the comprehensive mental health action plan 2013-2020 and urged Members States to implement the action plan as adapted to national priorities and specific circumstances. The action plan recognises the essential role of mental health in achieving health for all people. It is based on a life-course approach, aims to achieve equity through universal health coverage and stresses the importance of prevention. Its overall goal is to promote mental well-being, prevent mental disorders, provide care, enhance recovery, promote human rights and reduce the mortality, morbidity and disability for persons with mental disorders. The four objectives of the action plan are to:

²⁵ The Ottawa Charter for Health Promotion was issued after the first International Conference on Health Promotion organised by the World Health Organization in 1986. It advocates for the goal of "Health For All" by the year 2000 through better health promotion. Five action areas were identified, namely building healthy public policy, creating supportive environments, strengthening community action, developing personal skills, and re-orienting health care services toward prevention of illness and promotion of health.

²⁶ The Bangkok Charter for Health Promotion in a Globalized World is an outcome of the 6th Global Conference on Health Promotion held in Bangkok, Thailand in 2005. It builds upon the values, principles and action strategies of health promotion established by the Ottawa Charter for Health Promotion and calls for actions among member states to address the determinants of health in a globalised world through health promotion. Four key commitments are made, they are to make the promotion of health 1) central to the global development agenda; 2) a core responsibility for all of government; 3) a key focus of communities and civil society; and 4) a requirement for good corporate practice.

²⁷ Barry, Margaret M. "Promoting Positive Mental Health and Well-Being: Practice and Policy." *Mental Well-Being: International Contributions to the Study of Positive Mental Health* (2012): 355.

²⁸ Relevant information is contained at http://www.who.int/mental_health/WHA65.4_resolution.pdf

- (i) strengthen effective leadership and governance for mental health;
- (ii) provide comprehensive, integrated and responsive mental health and social care services in community-based settings;
- (iii) implement strategies for promotion and prevention in mental health; and
- (iv) strengthen information systems, evidence and research for mental health.

Regional Agenda for Implementing the Mental Health Action Plan 2013-2020 in the Western Pacific

1.2.4 In October 2014, the Western Pacific Regional Office (WPRO) endorsed the Regional Agenda for Implementing the Mental Health Action Plan 2013-2020 in the Western Pacific which features a phased approach with core, expanded and comprehensive implementation options. The regional agenda provides a framework to prioritise and accelerate mental health policies and actions in Member States. Under the objective of implementing strategies for promotion and prevention in mental health, the core implementation options are to:

- (i) convene a multisectoral group of stakeholders including educators, social workers, organised groups of artists, athletes, the media, leaders in culture and art to develop a national mental health promotion plan of action.
- (ii) use international good practices on educating the public, school- and workplace-based programmes, sports, culture and the arts to build resilience and promote mental health, adapting/contextualizing into the sociocultural situation.
- (iii) increase public, political and media awareness of the magnitude of the problem, and the availability of effective prevention strategies.
- (iv) increase mental health awareness among the health professionals to decrease stigmatisation and discrimination.
- (v) identify systems, programmes, projects or activities in which suicide prevention advocacy could be initially integrated.

1.3 Strategies and Approaches in Other Countries

1.3.1 Mental health occupies a prominent position on the health agenda globally. In keeping with the international momentum, mental health promotion policy and practice have been introduced and strengthened in many countries. Mental health strategies and approaches in overseas have evolved from a service provision focus to that of promotion of mental well-being of the population. Countries and regions such as Europe²⁹, United States³⁰, United Kingdom³¹, Australia³² and Singapore³³ have been adopting common health promotion approaches in mental well-being promotion, in addition to strengthening existing mental health services for mentally ill patients.

1.3.2 A review on overseas mental health promotion programmes which are national-wide, long-term or sustainable, and target at general population or specific target groups was conducted. A total of 25 programmes (three from Australia, two from New Zealand, four from the United Kingdom (UK), eight from Canada, one from the United States of America (USA) and seven from Singapore) were identified to learn about their best practices. Programmes which are well evaluated and demonstrated to yield health, social and economic benefits include the “Act-Belong-Commit Campaign” in Australia, “Time to Change” and “Five Ways to Wellbeing” in the United Kingdom, and “Like Minds, Like Mine” in New Zealand. A summary account of these programmes is at **Annex B**.

²⁹ WHO Europe (2005) *Mental Health Action Plan for Europe: Facing the Challenges, Building Solutions*. WHO European Ministerial Conference on Mental Health, available at http://www.euro.who.int/_data/assets/pdf_file/0013/100822/edoc07.pdf

³⁰ Centers for Disease Control and Prevention (2010) *Public Health Action Plan to Integrate Mental Health Promotion and Mental Illness Prevention with Chronic Disease Prevention, 2011–2015*, available at http://www.cdc.gov/mentalhealth/docs/11_220990_Sturgis_MHMIActionPlan_FINAL-Web_tag508.pdf

³¹ Department of Health (UK) (2011) *No Health Without Mental Health: A cross-government mental health outcomes strategy for people of all ages*, available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213761/dh_124058.pdf

³² Council of Australian Governments (2012) *The Roadmap for National Mental Health Reform 2012–2022*, available at <http://www.coag.gov.au/sites/default/files/The%20Roadmap%20for%20National%20Mental%20Health%20Reform%202012-2022.pdf.pdf>

³³ Chong SA, Vaingankar JA, Subramaniam MI (2012) Policy Implications of The Singapore Mental Health Study. *Ann Acad Med Singapore* 2012;41:258-63

1.3.3 Summarising the evidence, those programmes with mass media and social marketing interventions, particularly if they are supported by local community actions, have been shown to make a significant impact on public knowledge, attitudes and behavioural intentions and are cost effective. While mass media can be most effective at raising awareness and changing the climate of public opinion, changing behaviour requires more direct actions at the community level.

1.4 Current Situation in Hong Kong

1.4.1 Mental health problem is a major public health concern in Hong Kong. The Hong Kong Mental Morbidity Survey 2010-2013³⁴ conducted by the Hong Kong Mental Morbidity Survey Team revealed that the prevalence of common mental disorders among Chinese adults aged from 16 to 75 was 13.3%. The most common disorders were mixed anxiety and depressive disorder (6.9%), followed by generalised anxiety disorder (4.2%), depressive episode (2.9%), and other anxiety disorders including panic disorders, all phobias and obsessive compulsive disorder (1.5%). According to the Behavioural Risk Factor Survey conducted by the Department of Health (DH) in 2014, 4.8% of the general public aged between 18 and 64 could be classified as having severe non-specific psychological distress³⁵. Due in part to better awareness and detection of mental health problems, the demand for Hospital Authority's (HA) services has been on the rise, as evident in the increase in the number of patients with mental illness under its care from about 187 000 in 2011-12 to over 226 000 in 2015-16.

1.4.2 In addition, mental health problem of children and adolescents is an increasing concern in Hong Kong. The early stage of life presents an important opportunity to promote mental health and prevent mental disorders as up to 50% of mental disorders in adults begin before the age of 14 years³⁶. A local study presented the respective prevalence estimates of anxiety disorders (6.9%), oppositional defiant disorder (6.8%), attention deficit hyperactivity disorder (3.9%), conduct disorder (1.7%), depressive disorders (1.3%), and substance use

³⁴ Lam LC, Wong CS, Wang MJ, et al. (2015). Prevalence, psychosocial correlates and service utilisation of depressive and anxiety disorders in Hong Kong: the Hong Kong Mental Morbidity Survey (HKMMS). *Soc Psychiatry Psychiatr Epidemiol*. Published online first: 2015 Feb 8. DOI: 10.1007/s00127-015-1014-5.

³⁵ Department of Health (2015). *Behavioural Risk Factor Survey (April 2014)*. Hong Kong: Department of Health.

³⁶ Kessler RC, Berglund P, Demler O, et al. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Arch Gen Psychiatry*. 2005 Jun; 62(6):593-602.

disorders (1.1%) among high school adolescents³⁷. Authoritarian parenting, low parental warmth and high maternal over-control are associated with mental health problems including suicidal ideation among adolescents in Hong Kong.

Role of Department of Health in Mental Health Promotion

1.4.3 DH has been promoting mental well-being by enhancing public awareness through education and publicity using a life-course and setting-based approach.

1.4.4 For young children and their parents, parenting programmes are offered to parents attending DH's Maternal and Child Health Centres (MCHCs) which aim to strengthen parents' capacity in bringing up healthy, happy and well-adjusted children. Development of children is monitored in partnership with parents and pre-school teachers through the Developmental Surveillance Scheme. Young children suspected to have developmental or behavioural problems are referred to Child Assessment Centres for further assessment.

1.4.5 For primary and secondary students, Student Health Service Centres of DH provide annual appointments for assessment of their physical and psychosocial health. Psychosocial health is assessed with the use of questionnaires completed by students and/or their parents as appropriate. Professional staff will then provide individual counselling according to the information provided. Health education on mental well-being including stress management and how to enhance self-esteem etc. will also be delivered. Students with psychosocial problems identified will be referred to clinical psychologists, school social workers, Social Welfare Department, non-governmental organisations or specialist clinics as appropriate for further assessment and follow-up.

1.4.6 For secondary students, DH has also established an Adolescent Health Programme (AHP) which promotes physical and psychosocial health of adolescents through outreach school-based activities for students, parents and teachers. The AHP is provided by a multi-disciplinary team comprising doctors, nurses, social workers, clinical psychologists and dietitians. The Basic Life Skills Training Programme under AHP is tailored-made for junior secondary students covering topics on emotion and stress management,

³⁷ Leung PWL, Hung SF, Ho TP, et al. (2008). Prevalence of DSM-IV disorders in Chinese adolescents and the effects of an impairment criterion: a pilot community study in Hong Kong. *Eur Child Adolesc Psychiatry*. 2008 Oct;17(7):452-461.

harmonious interpersonal relationship building, communication skills and self-awareness, etc. Such training serves to empower adolescents to cope with changes and challenges during growth and development by establishing positive attitude and strengthening resilience.

1.4.7 For adults, DH manages a designated website under the Men's Health Programme to improve men's physical, mental and social well-being. Furthermore, an enquiry email account is provided for public to offer Questions and Answers service on men's health concerns and problems. As for pregnant women and postnatal mothers, under the Comprehensive Child Development Service, MCHCs act as one of the platforms for early identification of pregnant women and postnatal mothers with mood or mental health problems, and families with psychosocial risks. Families in need are referred to the appropriate health and social service for further management.

1.4.8 For elderly persons, the Elderly Health Service (EHS) of DH adopts a multi-disciplinary approach in promoting the mental health of elders and their carers through its Elderly Health Centres (EHCs) and Visiting Health Teams (VHTs). EHS aims at enhancing the awareness of elders, their carers, and the general public about the importance of mental health, the common mental health problems in elders and their prevention, through various channels such as health talks, seminars, books, audio-visual materials, webpages and the mass media. The VHTs reach out into the community and residential care settings to deliver on-site education and training. A wide range of topics are covered which include common mood problems, stress management, prevention of social isolation and elder abuse, building cognitive reserve, and skills for caring of elders with dementia. At the EHCs, reference is made to the Hong Kong Reference Framework for Preventive Care for Older Adults in Primary Care Settings when integrated primary care services are provided. Members of EHCs are assessed on mood and cognitive function during health assessments and managed accordingly.

1.4.9 The Primary Care Office of DH has published the reference frameworks for care of different population groups, namely children and older adults. These reference frameworks provide common reference to healthcare professionals for the provision of continuing, comprehensive and evidence-based care in the community, empower patients and their carers, and raise public awareness of the importance of the proper prevention and management of chronic diseases, as well as health promotion and disease prevention for different population groups. Mental well-being is among the health issues being promoted through these reference frameworks.

1.4.10 Apart from the above, DH has produced a comprehensive range of related health educational resources including publications, printed materials, multimedia resources, pre-recorded telephone information hotline and designated websites.

1.5 Mental Health Promotion Campaign

1.5.1 Making reference to DH's work in the promotion of mental health and mental well-being, the Review Committee considers it necessary to review the existing mental health promotion strategy of the Government to meet the changing needs and environment of the society in Hong Kong.

1.5.2 Based on the recommendation of the Review Committee, the Chief Executive announced in the 2015 Policy Address to launch a territory-wide public education and publicity campaign to promote the importance of mental health and mental well-being. The Advisory Group on Mental Health Promotion (Advisory Group) chaired by the Under Secretary for Food and Health and vice-chaired by the Director of Health was set up under the Review Committee in June 2015 to oversee the planning, implementation and evaluation of the campaign. Members include representatives from the Administration, non-governmental organisations (NGOs), professional associations, academia, patient group, school, business, public relations, business and sports sectors. The membership list of the Advisory Group is at **Annex C**.

1.5.3 Making reference to the Mental Health Action Plan 2013-2020 by the World Health Organization (WHO) and the Regional Agenda for Implementing the Mental Health Action Plan 2013-2020 in the Western Pacific, as well as taking into account overseas population-based and effective mental health promotion programmes, a three-year territory-wide mental health promotion campaign, namely Joyful@HK (好心情@HK) Campaign (the Campaign) was officially launched in January 2016.

1.5.4 This Campaign aims to share the message of enhancing mental well-being through a joyful mood. The Campaign slogan is "Fun • Feel • Share" (全城 FUN 享正能量) which consists of three key components of mental well-being. "Fun" conveys the meaning of enjoyment in life; "Feel" represents the outcomes of positive thinking; "Share" implies social interaction with others. The Campaign logo adopts a smiley face (Figure 1.2) as to express a joyful mood. It is being outlined by different colours and strokes to bring out the message that a multi-dimensional approach, including the practice of "Sharing", "Mind" and

“Enjoyment”, attributes to a good psychological condition or joyful mood of a person. The nose of the smiley face also resembles the first alphabet letter “J” of the Campaign name “Joyful@HK”.

Figure 1.2 Logo of Joyful@HK



1.5.5 The objectives of the Campaign are to (i) increase public engagement in promoting mental well-being; and (ii) increase public knowledge and understanding about mental health. The Campaign targets at the general public of different age groups, and engaging stakeholders and organisations that organise or facilitate activities for the promotion of mental health. Making reference to the principles from the Mental Health Action Plan 2013-2020³⁸ by WHO and those from the Promoting Health in Hong Kong: A Strategic Framework for Prevention and Control of Non-communicable Diseases³⁹ by DH, the principles adopted by the Campaign are universal, population-based, life-course and setting-based, with evidence-based approaches through social marketing, empowerment to public, engagement of stakeholders, establishment of community partnership and provision of supportive environment to promote mental well-being.

1.5.6 After taking into account overseas experiences and results from a local focus group study, the ways to achieve or enhance mental well-being are categorised under three main themes (SME): “Sharing”, “Mind” and “Enjoyment” (Figure 1.3).

³⁸ World Health Organization (2013). *Mental Health Action Plan 2013-2020*. Geneva: World Health Organization.

³⁹ Department of Health (2008). *Promoting Health in Hong Kong: A Strategic Framework for Prevention and Control of Non-communicable Diseases*. Hong Kong: Department of Health.

Figure 1.3 - Definitions of “Sharing”, “Mind” and “Enjoyment” (SME)



- “S - Sharing”: Sharing with family and friends and offering support to the needy.
- “M - Mind”: Keeping an open mind, perceiving things with a positive attitude and optimism.
- “E - Enjoyment”: Engaging in enjoyable activities to maximise potential and achieve satisfaction.

1.5.7 On the other hand, taking into account the local prevalence and the resources for the Campaign, one common mental health problem is selected for each age group. The selected mental health problems are anxiety disorders for adolescents, mixed anxiety and depressive disorder for adults, and dementia for the elderly respectively. By increasing public’s knowledge and understanding of these disorders commonly found in different age groups, it is hoped that these disorders could be detected and treated earlier, and stigmatisation could be reduced. A second slogan “Mental Health Matters Let’s Stand Together” (精神健康齊面對 同心同行衝過去) has been designed for the purpose and the key messages are as below:

- Mental well-being concerns everyone. “Sharing”, “Mind” and “Enjoyment” apply to all.
- Mental health problems are common. It is therefore important for all to understand the risk factors and symptoms of common mental health problems and know when to seek help and treatment.

1.5.8 Evidence revealed that social marketing and media advocacy are more effective when combining with other interventions, particularly community action. Therefore, a combined approach of mass media and community action has been adopted for the Campaign. There are four key components of the Campaign, namely:

- Mass media advertising and publicity activities
- Engagement of stakeholders
- Community partnership programmes
- Research and evaluation

Progress of Joyful@HK Campaign

1.5.9 The progress of the implementation of each of the component of the Campaign is highlighted below: -

Mass Media Advertising and Publicity Activities

1.5.10 The kick-off ceremony of the Campaign, officiated by the Chief Secretary for Administration, was held on 29 January 2016. At the ceremony, Ms. Sammi Cheng (鄭秀文) was appointed as the Campaign Ambassador to help promote and raise awareness for the Campaign. Ms. Cheng has a personal history of depression and is dedicated to share her experience, help those in need and promote mental well-being. Ms. Cheng, together with Ms. Ellen Loo (盧凱彤) and Mr. Lin Xi (林夕) have also prepared a theme song, entitled “Through the Hurdles (衝過去)” for the Campaign. A music video for the Campaign has been developed and broadcast.

1.5.11 A thematic website (www.joyfulathk.hk) for the Campaign has also been developed, which features a page called “My Pledge”, on which public can make “Sharing”, “Mind” or “Enjoyment” pledges by selecting their desired icons and messages. A number of celebrities and guests have already made their pledges. A Facebook fan page (fb.com/joyfulathk) for the Campaign has also been launched.

1.5.12 Immediately following the launching ceremony, a series of mass media advertising and publicity activities for various target groups (i.e. adolescents, adults and the elderly) through different advertising and publicity channels (including mass, electronic, printed and social media) has been carried out.

1.5.13 In 2016, a new TV and radio Advertisement in the Public Interest (API) featuring SFH, on “Sharing, Mind and Enjoyment” has been widely broadcast in various channels. Posters and pamphlets on “Tips on being joyful” and health education tools have been widely distributed. Advertisement was placed in public transport, newspapers, Internet and social media platforms. A radio programme targeting at the general public and the elderly was broadcast between end January and April 2016. In order to reach out to the community,

the Joyful@HK Promotion Van (「即笑即影·好心情」宣傳車) travelled to different districts in Hong Kong from 22 February to 22 March 2016 to deliver the key messages of the Campaign. Four panel comic strips on tips for being joyful and handling challenging situations targeting at adolescents and young adults were published on the Facebook fan page from June to September 2016. The Joyful@HK Run (好心情喜動跑) was organised on 11 December 2016 to encourage the public to enjoy life and perform more aerobic activities with their family and friends.

1.5.14 Application for Your Joyful Record Video Competition (「記錄好光影，滿載好心情」短片創作比賽) started in January 2017 and another new TV and radio API featuring the Campaign Ambassador, on common mental health problems has been widely broadcast in various channels since March 2017. Another series of posters and pamphlets on “Understanding common mental health problems” have been widely distributed. Another round of advertisement in public transport, newspapers, Internet and social media platforms has been carried out. TV programmes 《大腦不老》和《心情約會》 for arousing public awareness and increase their understanding on dementia and common mental health problems respectively have been broadcast between March and April 2017. Other initiatives in the pipeline include Facebook gimmicks and production of short videos.

1.5.15 The Advisory Group will further meet to steer the development and implementation of the mass media advertising and publicity activities of the Campaign for 2017-18 with a closing ceremony scheduled for early 2018.

Engagement of stakeholders

1.5.16 A key strategy in the development of community mental health promotion is collaborative engagement of stakeholders which leverage existing strengths and resources⁴⁰. Furthermore, involving local people in the implementation ensures both local commitment and relevance, which are essential for campaign success⁴¹. The need for partnership with sectors other than health has also been identified as necessary to more effectively address the social determinants of mental health and well-being⁴². As such, DH is

⁴⁰ Jané-Llopis, E, & Barry, M. (2005). What makes mental health promotion effective? *Promotion and Education*, 12(Supplement 2), 47-55.

⁴¹ Annor, S, & Allen, P. (2008). Why is it difficult to promote public mental health? A study of policy implementation at local level. *Journal of Public Mental Health*, 7(4), 17-29.

⁴² Quinn, N, & Biggs, H. (2010). Creating partnerships to improve community mental health and wellbeing in an area of high deprivation: lessons from a study with high-rise flat residents in east Glasgow. *Journal of Public Mental Health*, 9(4), 16-21.

engaging and exploring collaboration with relevant stakeholders, including relevant government bureaux/departments, District Councils, mental health services providers, non-government organisations (NGOs), patient groups, healthcare providers, academic institutions and so on. Using their expertise, experience and established networks, a synergistic effect can be achieved.

1.5.17 To increase students' engagement in promoting mental well-being, DH collaborated with the Education Bureau to launch the "Joyful@School Campaign" in August 2016, which aims to enhance understanding of mental health among teachers, students and parents, and to encourage students to think from different angles in the face of challenges, understand and accept mental health services and seek help from others when necessary.

1.5.18 Moreover, to further enhance the promotion of mental health in the working population, the "Joyful@Healthy Workplace Programme", jointly organised by DH and the Occupational Safety and Health Council, also commenced in August 2016 to promote healthy eating, physical activity and mental well-being among employers and employees in workplaces. The Programme features the "Joyful@Healthy Workplace Charter" and the "Joyful@Healthy Workplace Best Practices Award".

Community Partnership Programmes

1.5.19 In order to provide supportive environment and empower the public to engage in actions to promote mental well-being and to enhance their knowledge and understanding of common mental health problems, DH has designed community partnership programmes involving academics, NGOs and Healthy City Projects. The objectives of the community partnership programmes are to (a) devise, implement and evaluate interventions in the community for adolescents, adults and the elderly to achieve the Campaign objectives, and (b) develop evidence-based interventions and training materials that could be further adopted by different community partners at the end of the Campaign for further promulgation. The community partnership programmes have been commissioned by the Food and Health Bureau via the Health Care and Promotion Fund to the University of Hong Kong and the Chinese University of Hong Kong. Both programmes have commenced in early 2017.

Research and Evaluation

1.5.20 Pre-and post-Campaign surveys to monitor the changes in the general public's knowledge, attitude and behaviour related to mental well-being and common mental health problems, as well as evaluate the effectiveness of the Campaign have been put in place. DH has commissioned the Department of Psychiatry of the Chinese University of Hong Kong to conduct the pre-Campaign survey from November to December 2015 with a press conference to announce the results held in September 2016. The post-Campaign survey will be conducted towards the end of the Campaign.

1.5.21 For the community partnership programmes, a robust evaluation framework for community interventions will be put in place. An evaluation report combining results of the pre and post-Campaign surveys and the community partnership programmes, with way forward for the Campaign will be compiled at the end of the Campaign.

1.6 Recommendation and Way Forward

1.6.1 Although the Mental Health Promotion Campaign is a time-limited project for three foundation years, the end of the Campaign will mark the beginning of a long-term promotion plan for Hong Kong. The Campaign will give the Government a clearer direction on the way forward in developing a long-term strategy and plan for mental well-being promotion in Hong Kong based on the experience and evaluation on this Mental Health Promotion Campaign.

1.6.2 The Government will continue to strengthen public education and promotion with a view to further enhancing public awareness and understanding of mental health and creating a more supporting and caring environment with less stigma on people with mental health needs. It may take time to reduce stigma of the general public on mental health problems or mental illness but we believe in our people in showing more concerns on their own mental well-being as well as others'.

Chapter 2 – Mental Health Services for Children and Adolescents

2.1 Introduction

The Importance of Child and Adolescent Mental Health

2.1.1 Child and adolescent mental health⁴³ is an essential part of overall health. Having a good start in life will help children and adolescents fulfil their potential, develop lifelong resilience to adversity and improve future life chances. On the contrary, children and adolescents with poor mental health are more likely to have academic underachievement, leading to poor employment status and social failure after growing up, and dependency on medical and social systems. Promoting the mental health of children and adolescents is for the benefit of the children and adolescents, their families and society as a whole. Figure 2.1 shows some background information on child and adolescent mental disorders.

Expert Group on Child and Adolescent Mental Health Services

2.1.2 Committed to promoting child and adolescent mental health, the Government sees a need to strengthen support for those with mental health needs in keeping with present-day circumstances. An Expert Group on Child and Adolescent Mental Health Services was therefore established in December 2013 under the Review Committee on Mental Health chaired by the Secretary for Food and Health to carry out this worthy mission. Comprising a broad representation of stakeholders (membership at **Annex D**), the Expert Group is tasked to articulate a service delivery model of care for children and adolescents with mental health needs and map out the future direction for development of child and adolescent mental health services.

2.1.3 Since its establishment, the Expert Group has examined the current state of mental health problems in children and adolescents (Section 2.2), reviewed the existing services provided to those with mental health needs and identified gaps that require further work (Section 2.3). The Expert Group has also formulated recommendations on how our existing model of care should be refined and services enhanced to meet the challenges arising from an increasing

⁴³ Refers to mental health of children and adolescents aged 0-17.

prevalence of mental health problems in children and adolescents (Sections 2.4 and 2.5).

2.1.4 Children are our future. The recommendations in this report reinforce the Expert Group's belief that supporting children and adolescents with mental health problems is the joint responsibility of parents, teachers, healthcare and social care professionals, as well as other caring players in the community. It calls for an effective partnership among family, school and other social institutions to enhance their resilience, prevent as far as possible a disorder from occurring by removing the cause, and limit a disability from getting worse by giving them the necessary support. For this, the Expert Group appeals to the concerted efforts of the community.

Figure 2.1 Understanding Child and Adolescent Mental Disorders

From attachment disorders, Autism Spectrum Disorders, Attention Deficit/Hyperactivity Disorder and other learning disorders in early childhood to mood/anxiety disorders, psychosis, eating disorders and substance abuse in adolescence, mental health problems of children and adolescents cover a broad range of cognitive, emotional and behavioural disorders that may require early intervention and/or life-long support. Mental disorders in children and adolescents vary according to their development stage, as illustrated below.

Typical age ranges for presentation of selected disorders*

Disorder	Age (Years)																	
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
Attachment	█	█	█															
Pervasive developmental disorders	█	█	█	█	█	█												
Disruptive behaviour			█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█
Mood/ anxiety disorder						█	█	█	█	█	█	█	█	█	█	█	█	█
Substance abuse												█	█	█	█	█	█	█
Adult type psychosis															█	█	█	█

**Note that these ages of onset and termination have wide variations, and are significantly influenced by exposure to risk factors and difficult circumstances*

Within the first few years of life, infants and young children can develop attachment disorders. These are characterised by a notable difficulty in bonding with parents, underregulation of emotions and poorly coordinated social development that is insensitive to others. A particularly difficult disorder to evaluate and treat is childhood autism, an example of a pervasive developmental disorder that can be diagnosed appropriately in the first three years of life by trained individuals. Accurate and early diagnosis can enable parents and education professionals to seek and obtain optimal interventions.

Figure 2.1 Cont'd

Between the ages of four and six years, the most common disorders include hyperkinetic disorder and conduct disorders. Specific developmental and hyperkinetic disorders are major risk factors for conduct disorders, which have a profound impact on social development. If untreated, they frequently continue into adolescence and adulthood and lead to dropping out of school, antisocial behaviour, a poor employment history and poverty in adulthood. This impairs parenting and leads to a self-perpetuating, inter-generational cycle.

Examples of emotional disorders are mood and neurotic disorders (for example, depressive episodes and obsessive-compulsive disorder), which typically develop during the school-age years and are easily identifiable by staff trained to treat mental disorders in children. Children and adolescents are better reporters of internal, subjective states (for example, anxiety and depression) than their carers. But if no one asks them how they are feeling, their symptoms may remain unrecognised.

In later childhood, between the ages of 12 and 18, mental and behavioural disorders due to psychoactive substance use can emerge. In many cultures, children are particularly impressionable and extremely eager to conform to the social norms defined by their immediate peers. They are thus susceptible to experimentation such as drug abuse, and may unintentionally become addicted to drugs. Addictions can become entrenched at an early age, and, if untreated, can lead to a lifetime of struggle and despair.

Finally, psychotic disorders such as schizophrenia (seen in adults) tend to become apparent in later adolescence. While less prevalent than the disorders noted above, psychotic disorders can be particularly severe and unremitting if untreated; early detection and effective treatment can markedly improve the course of such illness.

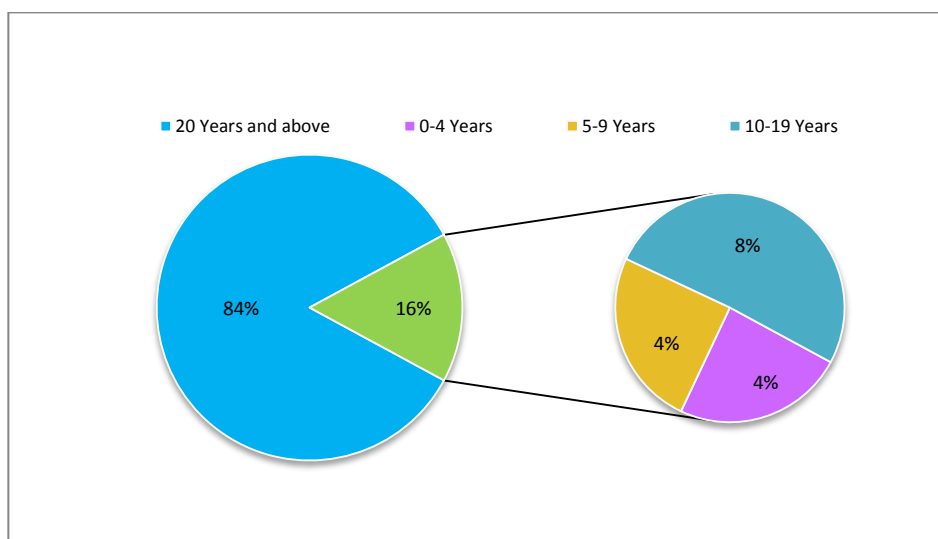
Source: Mental Health Policy and Service Guidance Package: Child and Adolescent Mental Health Policies and Plans, World Health Organization, 2005

2.2 Mental Illness in Children and Adolescents

Prevalence of Mental Illness in Children and Adolescents

2.2.1 According to WHO, up to 20% of children and adolescents worldwide suffer from a disabling mental illness.⁴⁴ Other national surveys and research on the prevalence of child and adolescent mental disorders by overseas jurisdictions suggest a range of 10%-20%. The WHO estimates that about 4% to 6% of children who have distressing or disabling psychiatric difficulties are in need of a clinical intervention for an observed significant mental disorder.⁴⁵ Figure 2.2 shows the population by age group in Hong Kong.

Figure 2.2 Hong Kong's Population by Age Group (Mid-2016)(Provisional)



Source: The Census and Statistics Department

A Snapshot of Our Current Situation

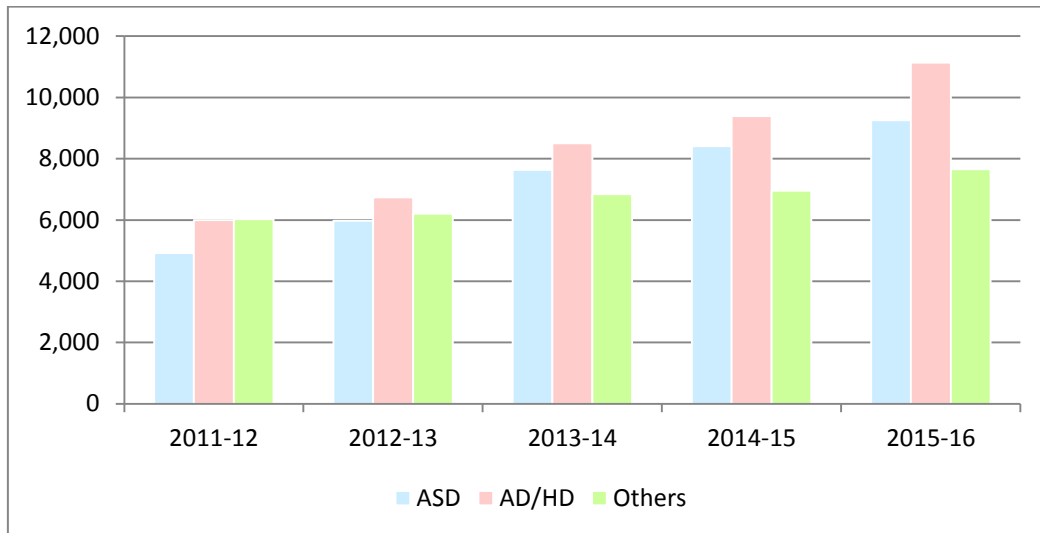
2.2.2 Although some less severe mental disorders may remit with the passage of time and with proper intervention, governments and service providers across the globe have reported increases in the incidence of mental health problems in children and adolescents, due in part to increasing awareness of the problems, better diagnostic tools, more refined diagnostic categories, and changing social/environmental stressors. In Hong Kong, the public system also observes a growing number of children and adolescents diagnosed with mental problems.

⁴⁴ Caring for Children and Adolescents with Mental Disorders, WHO, 2003.

⁴⁵ Atlas, Child and Adolescent Mental Health Resources, WHO, 2005.

2.2.3 As one indication, the caseload of the child and adolescent psychiatric teams of HA rose from 18 900 in 2011-12 to 28 800 in 2015-16, representing an increase by more than 50%. The major disorders present in these children are Autism Spectrum Disorders (ASD) and AD/HD, which make up over half of the caseload (Figure 2.3).

Figure 2.3 Caseload of HA’s Child and Adolescent Psychiatric Services



Some patients were categorised into more than one disease group in the same year.
Source: HA

2.2.4 Some disorders have a higher frequency of occurrence than others in specific age range. For example, among the cases being followed up by the child and adolescent psychiatric teams of the HA, there is a higher incidence and prevalence of ASD and AD/HD in early and middle childhood, while psychosis tends to become apparent in late adolescence and early adulthood. An analysis of the major mental disorders in children and adolescents by age ranges is at Figure 2.4a-c.

Figure 2.4a Types of Mental Disorder in Children Aged 0-5 Years (2015-16)
(N = 2 900)

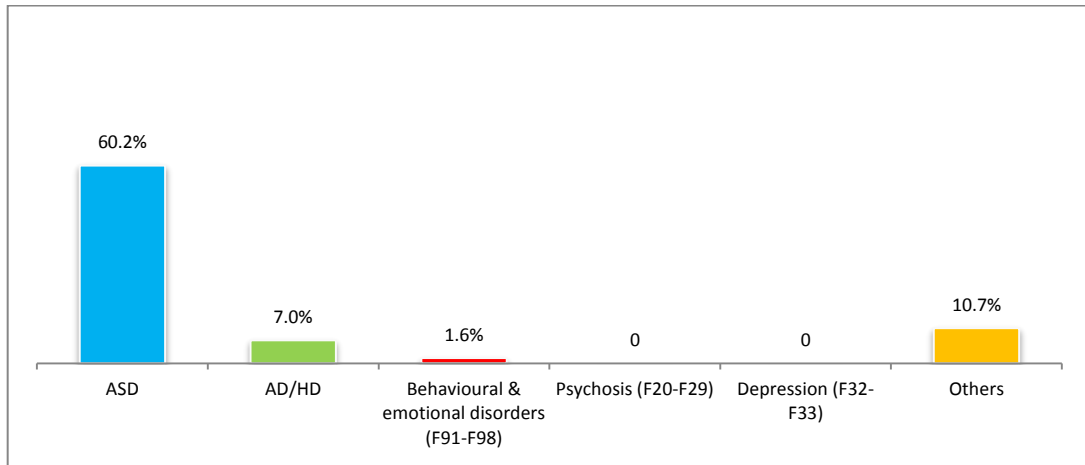


Figure 2.4b Types of Mental Disorder in Children/Adolescents Aged 6-11 Years (2015-16)
(N = 15 200)

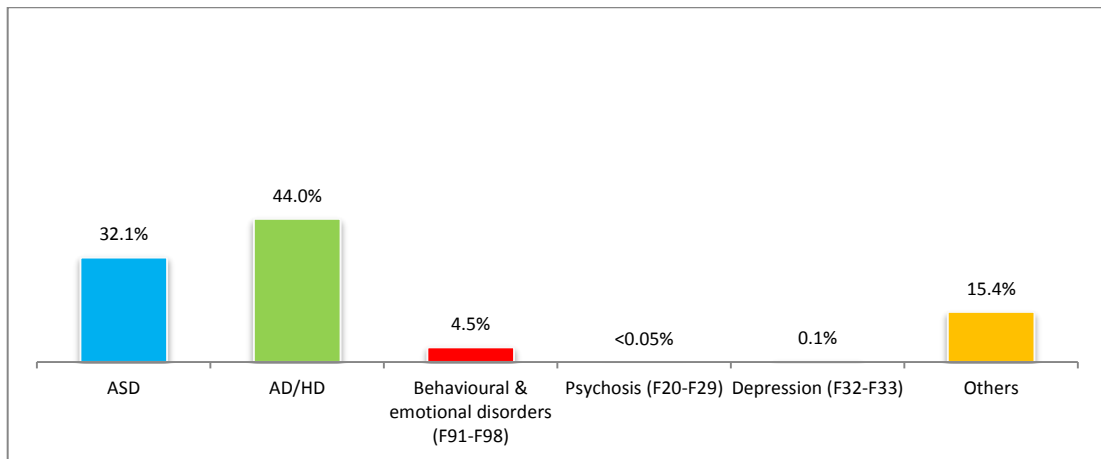
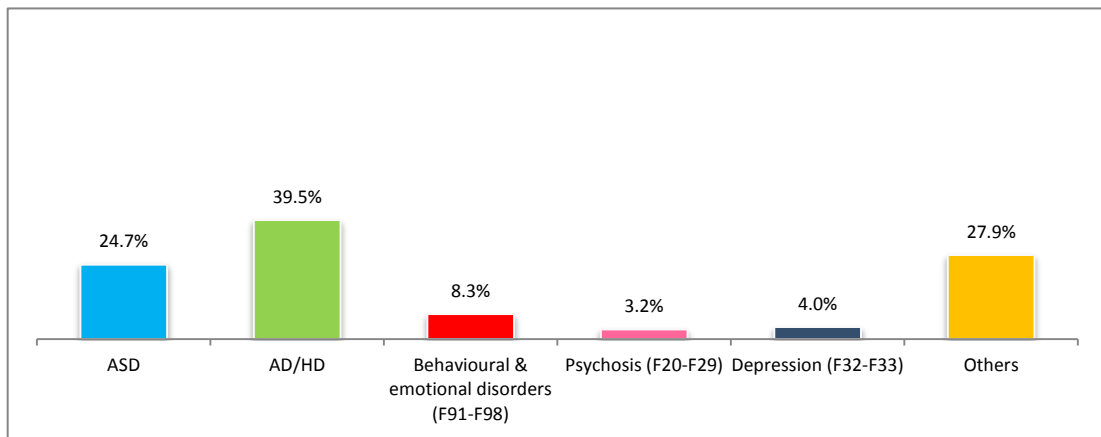


Figure 2.4c Types of Mental Disorder in Adolescents Aged 12-17 Years (2015-16)
(N = 10 800)



Some patients were categorised into more than one disease group in the same year.

Source: HA

Scope of the Problem

2.2.5 Scoping the prevalence of child and adolescent mental health issues is a complicated exercise⁴⁶. In Hong Kong, a study conducted in 2008⁴⁷ found that the overall prevalence estimate of mental disorders among the sampled adolescents was 16.4%. The prevalence estimates of various common mental disorders were largely compatible with those of other studies (Figure 2.5). No studies of similar scale have since been observed.

2.2.6 It is important to underline that, for each of the disorders discussed above and in the previous chapter, effective interventions are available. Accurate and early diagnosis will enable parents and teachers to seek and obtain optimal interventions. The key objective of early intervention is to reduce exposure to risk factors and promote protective factors (Figure 2.6) so that children can grow up in an enabling environment that is conducive to their healthy growth and development. Service providers will need to review and assess periodically the effectiveness of prevention and intervention programmes targeting specific age and disease groups.

⁴⁶ In addition to mental disorder or illness of children and adolescents, Members of the Expert Group have also discussed concerns on mental health issues that may arise in gifted children, as well as other behavioural issues such as eating disorders and hidden youth issue (“隱蔽青年”) commonly found among children and adolescents. The Expert Group considers that there is a need to address these issues in future so as to consider how best to enhance relevant support services provided by NGOs and by the Government. As regards gifted children, it is noted that the Hong Kong Academy for Gifted Education has been providing various support services to the children as well as their families and teachers.

⁴⁷ Leung, Patrick W.L., Hung, Se-fong., Ho, Ting-pong., Lee, Chiu-chiu., Lui, Wai-sum., Tang, Chunpan., Kwong, Shi-leung. (2008). Prevalence of DSM-IV disorders in Chinese adolescents and the effects of an impairment criterion. *European Child & Adolescent Psychiatry* (2008) Vol. 17, No. 7

Figure 2.5 Prevalence of Mental Disorders in Children and Adolescents

Mental disorders affect a significant number of children and adolescents worldwide. However, there was no meta-analysis to calculate a worldwide-pooled prevalence and to empirically assess the sources of heterogeneity of estimates until recently academics and researchers in Brazil conducted a meta-analysis of the worldwide prevalence of mental disorders in children and adolescents (see footnote 5).

The meta-analysis looked at 41 studies conducted in 27 countries from 1985 to 2012, including a study on the prevalence of mental disorders in adolescents in Hong Kong in 2008. The sample sizes ranged from 38 324 to 87 742. It was found that the worldwide pooled prevalence of mental disorders was 13.4%. The worldwide prevalence estimates of other major disorders are shown in the table below.

The meta-analysis also found significant heterogeneity in all pooled estimates. Geographic location of studies and year of data collection were not significant moderators of prevalence estimates. Juxtaposing the study on Hong Kong prevalence with the meta-analysis would find that the prevalence of mental disorders in the adolescent population of Hong Kong was broadly comparable to that in other parts of the world. And since geographic location of studies and year of data collection have been proved to be non-significant moderators of prevalence estimates, the prevalence estimates in the two studies provide useful reference in understanding the scale of the problem in Hong Kong and in service planning.

Prevalence of Mental Disorders in Children and Adolescents **(Worldwide vs Local)**

	Worldwide pooled prevalence % (95% CI) N= 38324 – 87742 Studies = 19 - 41	Hong Kong prevalence (young adolescents) % (95% CI) N = 541
Any disorder	13.4 (11.3 – 15.9)	16.4 (13.3 – 19.5)
Any anxiety disorder	6.5 (4.7 – 9.1)	6.9 (4.8 – 9.0)
Any depressive disorder	2.6 (1.7 – 3.9)	1.3 (0.3 – 2.3)
Major depressive disorder	1.3 (0.7 -2.3)	--
Any disruptive disorder	5.7 (4.0 -8.1)	--
Attention Deficit/Hyperactivity Disorder	3.4 (2.6 – 4.5)	3.9 (2.3 – 5.5)
Oppositional defiant disorder	3.6 (2.8 – 4.7)	6.8 (4.7 – 8.9)
Conduct disorder	2.1 (1.6 – 2.9)	1.7 (0.6 – 2.8)

Figure 2.6 Selected Risk and Protective Factors for Mental Health of Children and Adolescents

Domain	Risk Factors	Protective Factors
Biological	<ul style="list-style-type: none"> ✧ Exposure to toxins (e.g. tobacco and alcohol) in pregnancy ✧ Genetic tendency to psychiatric disorder ✧ Head trauma ✧ Hypoxia at birth and other birth complications ✧ HIV infection ✧ Malnutrition ✧ Other illnesses 	<ul style="list-style-type: none"> ✧ Age-appropriate physical development ✧ Good physical health ✧ Good intellectual functioning
Psychological	<ul style="list-style-type: none"> ✧ Learning disorders ✧ Maladaptive personality traits ✧ Sexual, physical and emotional abuse and neglect ✧ Difficult temperament 	<ul style="list-style-type: none"> ✧ Ability to learn from experiences ✧ Good self-esteem ✧ High level of problem-solving ability ✧ Social skills
Social		
a) Family	<ul style="list-style-type: none"> ✧ Inconsistent care-giving ✧ Family conflict ✧ Poor family discipline ✧ Poor family management ✧ Death of a family member 	<ul style="list-style-type: none"> ✧ Family attachment ✧ Opportunities for positive involvement in family ✧ Rewards for involvement in family
b) School	<ul style="list-style-type: none"> ✧ Academic failure ✧ Failure of schools to provide an appropriate environment to support attendance and learning ✧ Inadequate/inappropriate provision of education 	<ul style="list-style-type: none"> ✧ Opportunities for involvement in school life ✧ Positive reinforcement from academic achievement ✧ Identity with a school or need for educational attainment
c) Community	<ul style="list-style-type: none"> ✧ Lack of “community efficacy” (Sampson, Raudenbush & Earls, 1997) ✧ Community disorganization ✧ Discrimination and marginalization ✧ Exposure to violence ✧ Lack of a sense of “place” (Fullilove, 1996) ✧ Transitions (e.g. urbanization) 	<ul style="list-style-type: none"> ✧ Connectedness to community ✧ Opportunities for constructive use of leisure ✧ Positive cultural experiences ✧ Positive role models ✧ Rewards for community involvement ✧ Connection with community organizations including religious organizations

Source: *Mental Health Policy and Service Guidance Package: Child and Adolescent Mental Health Policies and Plans*, World Health Organization, 2005

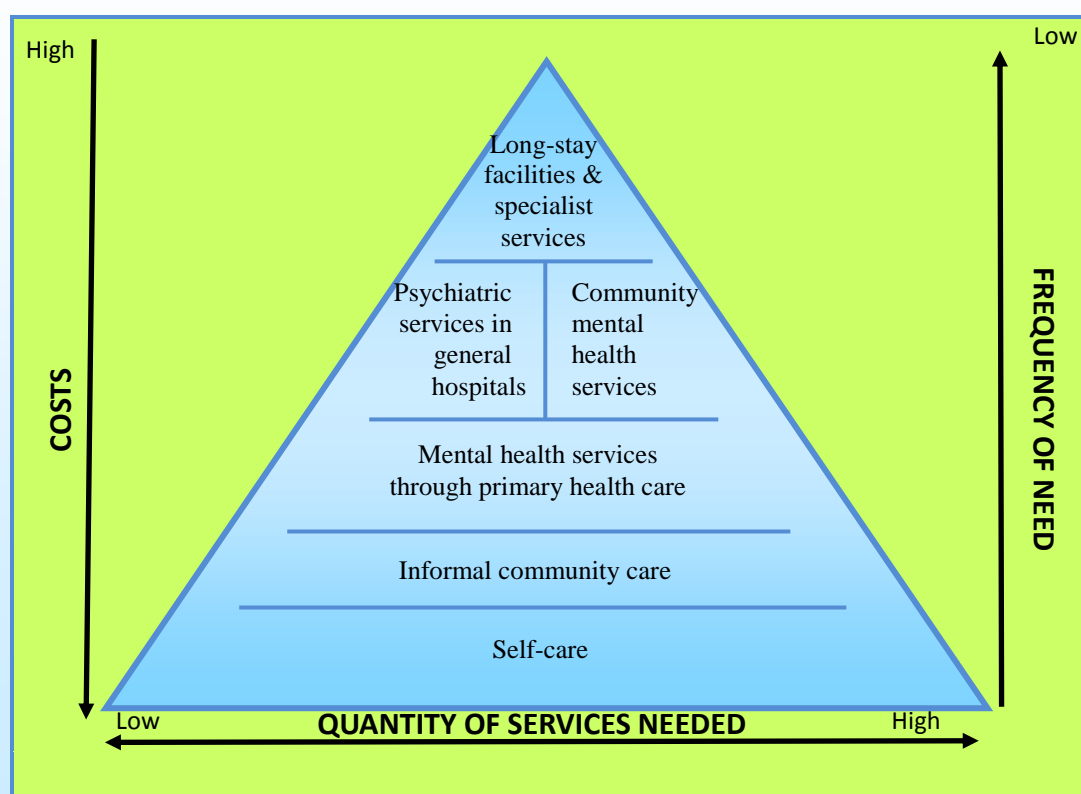
2.3 Mental Health Services for Children and Adolescents

Optimal Mix of Services

2.3.1 Given the wide spectrum of child and adolescent mental disorders, development of appropriate services is challenging for even the most developed countries. To help government plan service delivery, WHO recommends an optimal mix of services (Figure 2.7), which is based on the assumption that, generally, specific mental disorders will be present at specific age ranges during the course of child and adolescent development.

Figure 2.7 WHO-Recommended Optimal Mix of Services

WHO recommends an optimal mix of services, as illustrated in the figure below.



Source: Adapted from WHO, 2003

2.3.2 The Government follows more or less the WHO assumption in planning its mental health services, with services being built around the needs of children and adolescents at specific age ranges across various settings based

on the characteristics and prevalence of disease in each age band. The Government, including the FHB, LWB, EDB, DH, SWD and HA, adopts a multi-disciplinary and cross-sectoral approach in the provision of support and care for children and adolescents with mental disorders. The existing services provided by the Government are set out in the ensuing paragraphs.

Existing Services Along the Continuum of Care

Prevention and Early Identification

Antenatal and Postnatal Mental Health Problems

2.3.3 Comprehensive antenatal services are provided at the Maternal and Child Health Centres (MCHCs) of DH and obstetric clinics of HA under a shared care programme for pregnant women. At-risk pregnant women with suspected maternal mental health problems will be referred to receive counselling and other services.

2.3.4 Under the Comprehensive Child Development Service (CCDS), comprehensive and timely support is provided for children and their families in need through inter-sectoral collaboration among DH, HA, EDB, SWD and NGOs. CCDS uses MCHCs, hospitals under HA, Integrated Family Service Centres / Integrated Services Centres (IFSCs/ISCs) and pre-primary institutions as platforms to identify at-risk pregnant women, mothers with postnatal depression, families with psychosocial needs, as well as pre-primary children with health, developmental and behavioural problems. Children and families in need are referred to appropriate service units for follow-up. MCHCs conduct screening when providing postnatal care and child health services to identify mothers with probable postnatal depression and psychosocial issues and refer them for further assessment and follow-up treatment by psychiatric service of HA and social service at IFSCs/ISCs. Figure 2.8 summarises the number of cases identified and referred to appropriate health or social service for assessment and treatment because of antenatal and postnatal mental health problems at HA and MCHCs from 2013-14 to 2015-16.

Figure 2.8 Identification of Antenatal and Postnatal Mental Health Problems

	2013-14	2014-15	2015-16
At-risk pregnant women identified and followed up by HA Obstetric Clinics	2 231	2 312	2 311
Mothers identified to have probable antenatal / postnatal depression by MCHCs	7 262	8 542	8 086
Referral for follow-up management in the appropriate health and/or social service units by MCHC	4 724	5 415	4 985

Developmental Surveillance in MCHC

2.3.5 The Developmental Surveillance Scheme (DSS), targeting at children aged 0 to 5, has been launched since 2007 in all MCHCs to identify developmental problems and promote children's development. Under the Scheme, efforts are made to empower parents, carers and teachers with anticipatory guidance so that they become partners in promoting and monitoring the healthy development of children. Developmental and parenting information is provided through discussion with health professionals, leaflets, audio-visual clips, DVDs, hotline, internet as well as workshops.

2.3.6 Developmental Surveillance Questionnaires (DSQs) are routinely administered when a child visits MCHC for immunisation at the ages of 6 months, 12 months and 18 months. Children who require closer monitoring are further surveyed at other age intervals as appropriate (i.e. 2-month, 4-month, 9-month, 24-month, 36-month, 48-month and 60-month). Nurses at MCHCs will explain to carers findings of the DSQ and arrange developmental assessment by doctors if need be. Where necessary, children with developmental problems will be referred to child assessment centres under DH/HA⁴⁸, other specialists or social services for follow-up. Apart from the

⁴⁸ The Child Assessment Centre of the Duchess of Kent Children's Hospital under HA also provides child assessment service.

scheduled visits, parents can arrange an appointment with MCHCs whenever they have any concern on their children’s development.

2.3.7 As a part of CCDS implemented by DH, EDB, SWD, NGOs and HA, a referral and feedback mechanism among pre-school institutions, IFSCs/ISCs and MCHCs is in place for pre-primary children with suspected health, developmental or behavioural problems identified at child care centres, or kindergartens or in the community to be referred to MCHCs for initial assessment. For children requiring closer scrutiny, MCHCs will refer them to the child assessment centres under DH/HA or specialists of HA for further assessment by cross-disciplinary professionals. The total number of referrals to child assessment centres made by MCHCs is summarised in Figure 2.9.

Figure 2.9 Referral of Children with Suspected Developmental Problems to Child Assessment Centres made by MCHC

	2013-14	2014-15	2015-16
Referrals made by MCHC to child assessment centres	6 181	6 685	6 997

Parenting Education

2.3.8 Parenting education helps foster parenting capacity and strengthen the buffer to stresses that children may face. The parenting programme in MCHC aims to equip parents of children (0-5 years) attending the MCHC with the necessary knowledge and skills to bring up healthy and well-adjusted children. Parents are provided with anticipatory guidance on child development, childcare and parenting during the antenatal period and throughout the pre-school years of children. A more intensive parenting training (Triple P Programme) which targets at parents of children with early signs of behavioural problems and those who encounter difficulties in parenting is also available in all MCHCs.

Student Health Service

2.3.9 The Student Health Service (SHS) of DH provides health assessment services to students from Primary 1 to Secondary 6. Children and adolescents with suspected psychosocial health problems will be provided counselling services and may be referred to clinical psychologists or psychiatric specialists of HA, schools, SWD or NGOs for further assessment and follow-up where necessary. Figure 2.10 shows the number of students found to have suspected psychosocial problems (self-esteem problems and/or behavioural problems) between 2013-14 and 2015-16.

**Figure 2.10 Number of Students found to have
Suspected Psychosocial Problems by the Student Health Service**

	2013-14	2014-15	2015-16
Students with suspected self-esteem problems identified*	3 500	3 500	3 400
Students with suspected behavioural problems identified*	6 300	6 200	6 400

* Some students may have both suspected self-esteem problems and suspected behavioural problems.

2.3.10 SHS has also been providing various disease prevention and health promotion activities relating to substance use⁴⁹ and alcohol consumption in students.

2.3.11 SHS organises the Junior Health Pioneer Workshop for Primary 3 students when they attend the Student Health Service Centre (SHSC) for annual health assessment. The Workshop aims to increase students' knowledge on harmful effects of smoking, drug abuse and alcohol consumption, and to help them develop correct attitude towards refusal of substance abuse. SHS has also produced relevant health education materials, conducted health talks and a

⁴⁹ According to statistics of the Narcotics Division under the Security Bureau, the number of reported young drug abusers aged under 21 had continued to record a more substantial decline by 35%, from 1 223 in 2013 to 800 in 2014. The number of newly reported drug abusers in 2014 (at 2 008) was 23% lower than that of 2013 (at 2 623). Among them, those aged under 21 had decreased by 36% (from 744 in 2013 to 474 in 2014) and those aged 21 and over decreased by 18% (from 1 879 in 2013 to 1 534 in 2014). Compared with 2013, the average age of young drug abusers aged under 21 and their average age of first abuse remained at 18 and 15. As for all drug abusers, the average age had increased from 37 to 38 and average age of first abuse remained at 18;

smoking cessation programme for students. Health issues relating to body weight, including overweight and underweight, will also be monitored for individual student during the annual health assessment. Appropriate advice and management, including referral to specialist will be arranged if necessary.

Adolescent Health Programme

2.3.12 The Adolescent Health Programme (AHP) of SHS provides outreach programmes in school setting, targeting secondary school students, their parents and teachers. Through interactive programmes and health talks, the AHP aims to promote the psychosocial health of adolescents and enhance their resilience. Topics on refusal skills relating to tobacco, alcohol and substance use, as well as weight management are included. In 2015-16, there were around 320 schools (i.e. over 68% participation rate of local day secondary schools) and about 70 000 students, parents and teachers participating in the programme.

Assessment

Child Assessment Service

2.3.13 The CAS of DH provides comprehensive, multi-disciplinary assessment for children under the age of 12 with suspected developmental disorders. Children with developmental problems/children suspected of developmental disorders by schools or parents may be referred to CAS for a comprehensive assessment via registered medical practitioners or psychologists.

2.3.14 Adopting a multi-disciplinary approach, the CAS assessment team will evaluate a child's physical, cognitive, language, social and other development, and recommend rehabilitation services for them as necessary according to their individual needs and family circumstances. CAS also provides interim support for children who are waiting for placement in the relevant education and training services. Such support includes parenting programmes, workshops and practical training to help parents better understand their children's problems and care needs. A summary report of the assessment results will be provided to parents after the assessment, with a view to encouraging the parents to share the information with concerned organisations or school, and facilitating the children to seek support from these parties. And subject to the parents' consent, referrals will be made for related services in HA, SWD and EDB will provide

appropriate intervention, rehabilitation training and education support services according to the children's development needs. Figure 2.11 shows the number of children referred to the CAS.

Figure 2.11 Children being Referred to CAS

	2013-14	2014-15	2015-16
Children referred to CAS for assessment	9 127	9 431	9 982
Children referred to CAS for suspected behavioural or emotional problems	3 636	3 624	3 747
Newly diagnosed conditions			
- Attention Deficit/Hyperactivity Problem and Disorder	2 379	2 628	2 870
- Autism Spectrum Disorders	1 539	1 795	1 992
- Other Behavioural/Emotional Difficulties	585	630	708

Medical Intervention

Specialist Care

2.3.15 HA provides a spectrum of mental health services, including inpatient, outpatient and ambulatory services to children and adolescents with mental health problems. The multi-disciplinary professional teams of HA comprising healthcare practitioners in various disciplines, including doctors, clinical psychologists, nurses, speech therapists and occupational therapists, provide early identification, comprehensive assessment and treatment services for needy children or adolescents having regard to their individual circumstances. There are currently five hospitals providing child and adolescent psychiatric services for children and adolescents aged 18 or below. These hospitals are Queen Mary Hospital, United Christian Hospital, Kwai Chung Hospital, Alice Ho Miu Ling Nethersole Hospital and Castle Peak Hospital. In 2015-16, HA provided support to around 28 800 children and adolescents with mental health problems, which represented an increase of more than 50% from 2011-12.

2.3.16 Training is an important element in the overall treatment and management of children and adolescents having behavioural and psychiatric problems. With respect to training, it will be conducted on individual or group basis to help children and adolescents to develop their speech and

communication skills; to enhance their social and problem-solving skills; and to improve their behaviour adjustment and emotional management, as well as interpersonal relationships. The multi-disciplinary teams will also provide support for parents and carers so as to enhance the understanding of their children's disorders and treatment needs. In addition, the professional teams will maintain close collaboration with related service units such as schools and early training centres so as to make appropriate referrals and provide support according to the developmental needs of the children. Apart from providing training for children suffering from mental health problems, the SOPCs also provide support for parents and care-givers to help improve outcomes.

Child and Adolescent Mental Health Community Support Service (CAMCom)

2.3.17 The Child and Adolescent Mental Health Community Support Service (CAMCom), an extended arm of the HA Child and Adolescent service targeting individuals aged 6 to 18, provides a range of community support services to facilitate early identification and intervention for children and adolescents with anxiety and mood problems. The scope of service includes provision of proactive outreach services to community partners; conducting mental health promotion activities; providing early assessment and intervention for children and adolescents with anxiety and mood problems and making referrals for other community and specialist services.

Early Assessment Service for Young People with Early Psychosis (EASY) Programme

2.3.18 Noting that the first episode of psychosis usually occurs in a person's late teens or early twenties, HA has launched the EASY Programme to provide one-stop support for people suffering from early psychosis since 2001. Apart from conducting educational campaigns to raise the public's awareness about early psychosis and its symptoms, the Programme accepts referral of suspected early psychosis cases from the public via hotline, website or service centres. Upon referrals, multi-disciplinary teams led by doctors will conduct comprehensive assessment and formulate treatment plans, including medication, psycho-social interventions and rehabilitation programmes, for patients. The aim is to help patients resume a normal life, while limiting the adverse effects of their condition on them and their family members. About 1 300 new patients with psychotic disorders were diagnosed under the EASY Programme each year.

Education Services

Mental Health Promotion in Schools

2.3.19 Enhancing students' psychological health and promoting healthy living form an integral part of the school curriculum. A holistic curriculum comprising knowledge, values/attitudes and skills is adopted so as to help students understand issues relating to psychological health, ways to handle or stay away from stress, and to develop harmonious human relationship, etc. for their whole-person development. Elements of psychological health are covered in various Key Learning Areas (KLA)/subjects, such as the subject General Studies at primary level; the Personal, Social and Humanities Education KLA, the Science Education KLA and the subject Liberal Studies at secondary level. Besides, promotion of healthy living is also covered in Moral and Civic Education at both primary and secondary levels. Learning elements including psychological health, mental disorders, and services for mental patients have been included in the Health Management and Social Care curriculum implemented in schools at S4-6 level since 2009. Professional development programmes covering the elements of mental health education are provided to teachers to support schools for implementing the school curriculum. Schools are encouraged to enrich the school curriculum by life-wide learning activities, such as visits, community service, using the resources available in the school and the community, with a view to promoting students' psychological health and developing related skills and positive values and attitude for facing with adversities.

A Three-tier Intervention Model

2.3.20 EDB encourages schools to adopt a three-tier intervention model under which additional learning support is provided to students based on their individual needs. The level of support for different students will be adjusted according to the progress and needs of individual students. Tier-1 support provides quality teaching in the regular classroom to help students with mild or transient learning/behaviour adjustment difficulties. Tier-2 support refers to "add-on" intervention for students with persistent learning/behaviour adjustment difficulties. Tier-3 support provides intensive and individualised support to students with persistent and severe learning/behaviour adjustment difficulties.

2.3.21 Schools also detect and support students with mental health problems under the three-tier intervention model. Tier 1 targets at students who are vulnerable and requiring additional support through teaching, guidance and support activities mainly from teachers, such as life education programmes, peer support, home-school collaboration. Tier 2 targets at a smaller group of at-risk students referred to school social workers or school guidance teachers/personnel (SGT/SGP) for risk assessment and “add-on” support services, such as consultation or casework services for individuals, families and groups, programmes on healthy personal growth, as well as programmes to support their adjustment to school life by strengthening the linkage among students, families, the school and the community. Tier 3 focuses on the high-risk cases requiring in-depth assessment and intensive individualised support from specialised helping professionals, including psychiatrists, clinical psychologists, social workers, etc.

Additional Resources

2.3.22 To help primary and secondary schools support students with diverse needs, EDB has been providing schools in the public sector with additional resources, including Capacity Enhancement Grant, Learning Support Grant, Enhanced Speech Therapy Grant, additional teachers and funding under the Integrated Education Programme and Intensive Remedial Teaching Programme, additional teachers for secondary schools to cater for students with low academic achievement, etc. For students with severe behavioural and adjustment difficulties, EDB will consider providing schools with a time-limited grant where appropriate for employing teaching assistants to help the students concerned to establish classroom routines.

Professional Support

2.3.23 School professionals, including guidance teachers, school social workers and educational psychologists (EPs), provide support and guidance services for students with learning or adjustment difficulties (including students with special educational needs (SEN) and other mental health problems). If teachers suspect their students to have learning or adjustment difficulties and in need for professional assessment or consultation services, they may seek help from the professionals in their schools and, if necessary, refer the students to psychiatrists or specialists as appropriate for diagnosis or medication. If

necessary, schools will arrange multi-disciplinary case conference attended by psychiatrists, social workers, EPs and school personnel to discuss appropriate support measures for the students. The roles of schools are to help these students re-enter school and adapt to school life after treatment, in tandem with the medical treatment and rehabilitation requirements. Currently, all primary schools have student guidance teacher/personnel, and each secondary school is providing school social work service.

Teacher Training

2.3.24 To enhance the professional capacity of teachers in catering for students with diverse needs, from the 2007-08 school year onwards, the EDB has been providing serving teachers with relevant and structured training courses on supporting students with SEN pitched at Basic, Advanced and Thematic levels. Starting from the 2012-13 school year, EDB has offered a new round of professional development courses for teachers. The elective modules of the Advanced and Thematic Courses have been re-grouped into three categories, namely, (1) cognition and learning needs; (2) behavioural, emotional and social development needs; and (3) sensory, communication and physical needs. Thematic courses on behavioural, emotional and social development needs cover the knowledge and skills necessary for taking care of students with mental health problems. In addition, a 120-hour thematic course on Psychological Approach to Effective Strategies in Handling Students' Challenging Behaviour is organised annually to enhance teachers' understanding of students' developmental needs, including deviant and unruly behaviour, low self-esteem and some common emotional and psychiatric problems. Through discussions and case analysis, the course helps teachers develop positive attitudes and effective strategies for supporting students in handling potential cases with mental health issues in different stages of development.

Cross-sectoral Collaboration

2.3.25 To enhance the effectiveness of the support for students with SEN and those with mental health problems, the EDB works in collaboration with different sectors, such as other government departments, HA, NGOs in developing screening/assessment tools and diversified educational resources, as well as in organising school-based, district-based or territory-wide seminars,

workshops and talks to equip teachers with the necessary skills in managing students with diverse needs.

Social Rehabilitation Services

Pre-school rehabilitation services

2.3.26 SWD provides support to children, who are assessed mainly by the Child Assessment Centres of DH to be in need of early professional intervention, through subvented pre-school rehabilitation services at the Early Education and Training Centres (EETCs), Special Child Care Centres (SCCCs) and Integrated Programme (IP) in Kindergarten-cum-Child Care Centres.

2.3.27 EETCs are designed mainly for mildly to moderately disabled children from birth to the age of two, providing them with early intervention programmes with particular emphasis on the role of the disabled child's family. Disabled children aged between two and six can also receive the service if they are not concurrently receiving other pre-school rehabilitation services, which will facilitate their integration into the mainstream education system. SCCC provide special training and care for moderately to severely disabled pre-school children to facilitate their growth and development, helping them prepare for primary education. IP provides training and care to mildly disabled pre-schoolers in an ordinary kindergarten-cum-child care centre with a view to facilitating their future integration into the mainstream education as well as in society.

2.3.28 As at December 2016, there were 3 124 places for EETCs, 1 799 places for SCCC and 1 980 IP places for children with disabilities. The Government is proactivity seeking suitable sites for providing rehabilitation services. To increase the provision, the Government will provide about 1 470 additional pre-school rehabilitation places within its current term. In addition, LWB, in cooperation with NGOs, is in the process of implementing a Special Scheme on Privately Owned Sites for Welfare Uses whereby NGOs will redevelop the sites under their ownership to provide more welfare services including, among others, EETC and SCCC places. According to the preliminary estimate by the NGOs participating in this Special Scheme, 3 800 additional pre-school rehabilitation places could be provided.

Training Subsidy Programme for Children on the Waiting List of Subvented Pre-school Rehabilitation Services

2.3.29 The Community Care Fund (CCF) launched a means-tested “Training Subsidy Programme for Children on the Waiting List of Subvented Pre-school Rehabilitation Services” (TSP) in December 2011 to provide training subsidy to eligible children on the waiting list for subvented pre-school rehabilitation services with a view to enabling children from low-income families and in need of rehabilitation services to receive necessary services as soon as possible so as to facilitate their learning and development while waiting for subvented services. In view of the positive evaluation outcome of the CCF Programme, SWD has regularised the TSP with effect from 1 October 2014. Starting from 1 October 2016, SWD has increased the training hours per month under the TSP for eligible children on the waiting list for SCCCs. Starting from 2017-18, SWD will waive the fees of SCCCs and provide non-means-tested TSP for children on the waiting list for SCCCs.

Pilot Scheme on On-site Pre-school Rehabilitation Services

2.3.30 Recognising the importance of early intervention for children in need of rehabilitation services, SWD launched a two-year Pilot Scheme on On-site Pre-school Rehabilitation Services (Pilot Scheme) from November 2015 to January 2016, with allocation of over \$420 million from the Lotteries Fund. Under the Pilot Scheme, multi-disciplinary teams (comprising occupational therapists, physiotherapists, speech therapists, clinical/EPs, social workers and special child care workers) from 16 NGOs operating subvented pre-school rehabilitation services provide 2 925 on-site service places so as to benefit, as early as possible, children with special needs who are studying in over 480 kindergartens or kindergarten-cum-child care centres. The Pilot Scheme also provides professional support for kindergarten teachers/child care workers to assist them in working with children with special needs, and render support to the parents on fostering positive attitude and providing effective skills in raising their children with special needs. In addition, an annual sum of \$460 million has been earmarked for regularisation of the Pilot Scheme in future to provide up to 7 000 service places in phases.

Medical Social Services

2.3.31 SWD has stationed medical social workers (MSWs) in psychiatric hospitals and clinics of HA to provide medical social services to persons with mental health problems, including children and adolescents. MSWs provide timely psychosocial intervention to the service users and help them cope with or solve problems arising from their illness. MSWs are also members of the multi-disciplinary teams of the EASY Programme to offer one-stop support services to facilitate early detection and early intervention of mental health problems of young people.

Community Support Services

Integrated Family Service

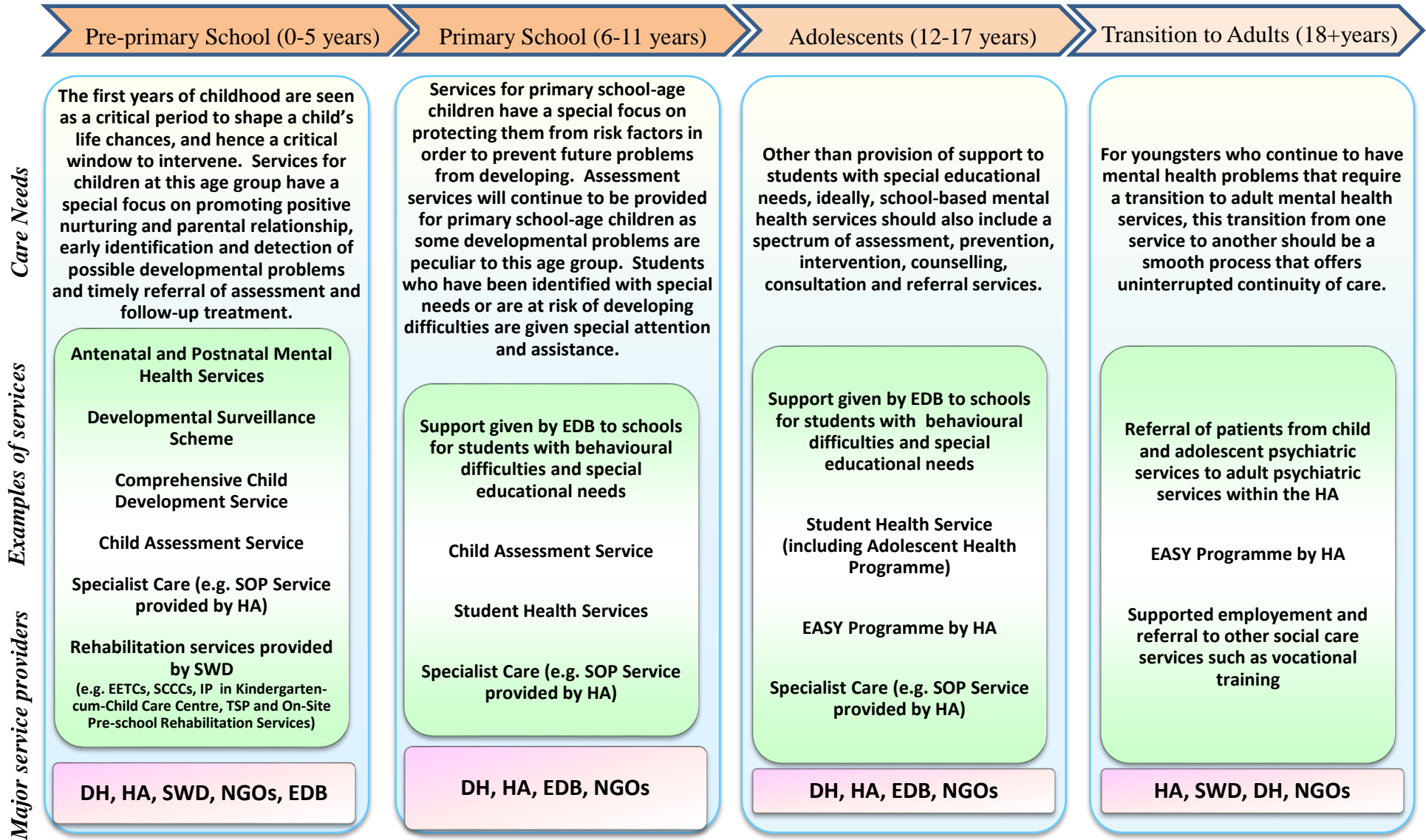
2.3.32 IFSCs and ISCs provide a spectrum of preventive, supportive and remedial services to address the multifarious needs of individuals and families of specific localities. The services include enquiry service, resource corner, family life education, parent-child activities, group work service, programme activities, volunteer training and service, outreaching service, counselling service and referral service, etc. for individuals and families in need. IFSCs/ISCs have close collaboration with MCHCs of DH, HA, pre-primary institutions, etc. to identify at-risk pregnant women, mothers with postnatal depression, as well as children and families in need including those with psychosocial needs, pre-primary children with health, developmental and behavioural problems, etc. Children and families in need are referred to appropriate service units for follow-up.

Integrated Community Centre for Mental Wellness

2.3.33 ICCMW is an integrated centre providing community support and social rehabilitation services ranging from early prevention to risk management for discharged mental patients and persons with suspected mental health problems aged 15 and above, as well as their families/carers. ICCMWs also conduct public education to enhance understanding of mental health and raise public awareness of early symptoms of mental health problems in the community.

2.3.34 Figure 2.12 shows the existing support by the Government and NGOs for children and adolescents with mental health problems.

Figure 2.12 Support for Children and Adolescents with Mental Health Needs



Service Gaps and Priority Areas for Action

2.3.35 The Government endeavors to provide a comprehensive range of services to support child and adolescents with mental health problems. Yet our existing services are not free of gaps (Figure 2.14) due to the complexity of the problems which straddle multiple disciplines and sectors. In anticipation of rising demand for child and adolescent mental health services, there is a need to take a fresh look at the current service delivery model and find ways to ensure the provision of holistic and coordinated care in a more sustainable, efficient and effective manner.

2.3.36 In this regard, the Expert Group had an opportunity to meet with some family members and representatives from four concerned groups and NGOs⁵⁰ to listen to their concerns on the existing mental health services for children and adolescents. Their major concerns on mental health services for children include the long waiting time for assessment and diagnosis in public hospitals, the financial burden of low-income families in using services (such as assessment, training, etc.) provided by private service providers, stress faced by parents and care-givers, the transition of support services from pre-school age to school age as well as from adolescence to adulthood, the ineligibility of school children with certain mental illness (such as depression, behavioural and emotional disorders, etc.) for subsidies entitled by SEN children⁵¹, parents' worry on the side effects of drugs prescribed⁵² to their children, and the inadequate support services and little coordination among multi-disciplinary professionals at schools to provide children with, or refer them to, relevant services. There was a suggestion to adopt a less stigmatising Chinese nomenclature for psychiatry service to replace “精神科” which had been discouraging children and adolescents to seek help.

⁵⁰ Including representatives from the Society for Community Organization, the Hon Fernando Cheung Chiu-hung's office and the Hong Kong Association for AD/HD, as well as frontline social workers referred by the Hon Cheung Kwok-che's office who had expressed concerns on the existing mental health services of children and adolescents.

⁵¹ Certain mental illness is not included in the eight types of SEN which cover hearing impairment, visual impairment, physical disability, intellectual disability, speech & language impairment, specific learning difficulties, AD/HD and ASD.

⁵² HA has taken measures in recent years to increase the use of new psychiatric drugs with less disabling side effects. In 2014-15, HA repositioned all new generation oral anti-psychotic drugs (except for Clozapine due to its side effects) from the special drug category to the general drug category in the HA Drug Formulary so that all these drugs could be prescribed as first-line drugs. Furthermore, the Coordinating Committee in Psychiatry provides a communication platform with clusters to discuss issues related to use of new psychiatric drugs. HA will continue to keep in view the development and review of the use of new psychiatric drugs through established mechanism.

2.3.37 As regards the mental health services for adolescents in need, the concerned groups proposed to conduct regular screening at schools to identify the proportion of children/adolescents with mental health problems at schools with a view to planning ahead the resources required for the provision of relevant services. They also saw the need to closely follow up the cases of school dropouts/ leavers, set up a case management programme to coordinate with different service units for the provision of relevant services to the adolescents, provide short-term/transitional accommodation specifically for adolescents⁵³ to alleviate the pressure on both the adolescents and their families, enhance the support to and training of teachers and parents and enhance the employment support to adolescents having left schools. As compared with the EASY programme, it was noted that waiting time of adolescents for assessment and diagnosis of common mental disorder was longer. There were also concerns on the lack of manpower resources to provide on-site support at schools for the prevention, early identification and intervention of adolescents with mental health problems.

2.3.38 Among all those service gaps identified, the priority areas for action are summarised in the ensuing paragraphs.

Public Education and Prevention

2.3.39 Children and adolescents with mental disorders are particularly vulnerable to stigma and discrimination. Yet the very talk of “mental health” is often associated with mental problems and disorders. This perception counters efforts in de-stigmatising mental illness and results in adverse help-seeking behaviour among young people and their carers. Public education is thus needed to promote awareness and acceptance while encouraging help-seeking behaviors to enable early intervention.

2.3.40 As psychiatric disorders in children and adolescents are closely associated with stressors, social and environmental factors, we need to promote greater understanding about the mental health needs of children and adolescents among parents, carers and teachers so that they can seek to prevent a disorder from occurring by reducing exposure to risk factors and enhancing protective factors, identify a problem at onset for early intervention and prevent it from worsening through proper support. Promotion of positive parent-child and teacher-student relationship,

⁵³ At present, SWD provides residential services (such as hostels, halfway houses, long-stay care homes) through NGOs to persons aged 15 or above with disabilities or mental health problems

physical exercises, healthy lifestyles, stress management, meaningful participation in schools and community, as well as social and emotional intelligence skills through education will also help build resilience against adversity.

At-risk Parents and Pre-schoolers

2.3.41 The close association between a child's upbringing and mental development is not disputed. To improve a child's future life chances, it is important to increase a child's exposure to preventive factors and reduce his exposure to risk factors. Although there are existing platforms such as MCHCs and programmes such as CCDS to help identify at-risk parents and families (e.g. parents with mental problems, drug problems, domestic violence), at-risk parents may not be willing to be referred for treatment or to receive help. More intensive, proactive and targeted effort is therefore required to engage these parents in support programmes such as through the strengthening of CCDS which currently tends to focus more on the well-being of the mothers so that developmental needs of children of at-risk parents could be identified to facilitate early intervention.

2.3.42 Quite a number of common child developmental problems are being diagnosed at early age (0-6 years). Support to children of this age group and their parents is inadequate to meet rising demand. The long waiting time of pre-school rehabilitation services put parents in a worrisome position and children of this age group may miss the optimal timing to receive intervention. There is also a need to enhance the knowledge and skills of pre-school teachers in the early identification and support to these children.

Transition from Pre-school Age to School Age

2.3.43 There are certain support services and subsidies (for example, the Pilot Scheme and TSP) provided by SWD for pre-schoolers with special needs. For school children, EDB has been providing schools in the public sector with additional resources, including Capacity Enhancement Grant, Learning Support Grant, Enhanced Speech Therapy Grant, additional teachers and funding under the Integrated Education Programme and Intensive Remedial Teaching Programme, etc. in order to help schools support students with diverse needs. As the mode of service delivery and the types of subsidies are different for pre-schoolers and school children, more coordination on the transition from pre-school age to school age is

required so as to facilitate the continuation of appropriate services for children in need.

School Children

2.3.44 While specialist services such as child and adolescent mental health services provide assessment and treatment, the ongoing management and support of children with mental health problems require multi-disciplinary and cross-sector collaborations as well as community-based and school-based support. At present, each school has a professional team consisting of a student guidance teacher/personnel and a school social worker supported by an EP who pays regular visits to school to discuss learning, social and behavioral issues of students in need collaboratively. Yet, there is no regular platform for multi-disciplinary collaborations between schools, community partners and healthcare professionals. More coordination among medical, social and educational sectors is required to facilitate regular discussions among professionals so that secondary prevention and timely interventions can be implemented. It is therefore important to enhance partnership among parents, schools, hospitals, and NGOs so that they all have equal responsibility and ownership to a child's problem and have shared accounts of a child's needs and follow up according to coordinated intervention plans.

2.3.45 Anxiety disorders, which have a prevalence rate of 7% and being the most prevalence of child psychiatric disorders, are under-represented. Unlike children with ASD and ADHD which are relatively notable, children with anxiety disorders may be timid and reserved. Therefore, children with anxiety disorders may escape adults' attention and thus do not receive assessment and services they need. Evidence shows that early management of anxiety problems can reduce the risk of depression in adolescents. It is therefore crucial that these children could be identified and referred to relevant services for follow-up as early as possible.

At-risk group - School Dropouts/Leavers

2.3.46 Mental health problems increase the risk of school dropouts and school leavers are vulnerable groups to mental health problems. However, it is difficult to reach these groups of adolescents and their problems may not be attended to promptly by healthcare, social care and education personnel. Mechanisms for early identification of these adolescents need to be put in place so as to facilitate timely assessments and formulation of treatment plans to prevent escalation of problems and further deterioration in functioning that may result in loss of productivity.

Transition from Adolescence to Adulthood

2.3.47 Young people who rely on mental health services might find it difficult to adjust to the change as they enter adulthood. They may disengage, and some even drop through the care gap between the two services and lose the much needed continuity of care. This will make them more likely to end up out of work and not in education/vocational training. More monitoring on the transitions from adolescence to adulthood is therefore needed, especially in the first few months when an adolescent is being transferred for adult services.

Optimising Mental Health Care for Youth

2.3.48 Youth begins from adolescence and ends at early adulthood (roughly aged between 15 and 25, Keniston, 1970). During this period, brain structural connections undergo fundamental re-wiring. Correspondingly, young people undergo psychological transformations characterised by changes in the sense of self, challenging attitudes and educational pressures (Patel et al., 2007). Youth is at a critical stage during which many serious mental disorders, such as schizophrenia, mood disorders and anxiety disorders emerge (Patel et al., 2007). Many of these disorders may cause long-lasting functional impairments if they are not well managed at an early stage. It is strategically important for mental health planning to address the mental health needs of youths in a more effective manner.

2.3.49 Despite evidences from international and local surveys showing that youths (aged between 12 and 25) have high prevalence of mental illness (10% to 15% prevalence, data from the Hong Kong Mental Morbidity Survey (HKMMS), Kessler et al., 2005), their engagement of mental health services is often the poorest among all age groups (HKMMS data 2015, Figure 2.13). One of the factors that contributes to the poor engagement by youths is that conventional platforms in clinic and the set-up of social welfare settings (such as psychiatric centres of hospitals and ICCMWs) are not youth-friendly enough to appeal young people with mental health needs to use their services. Therefore, there is a need to explore the feasibility of setting up a youth-friendly platform to encourage help-seeking of youths at risk of having, or with mental health problems.

Figure 2.13 Engagement by the age group of 16 to 25 and other age group for services on common mental disorders, psychotic disorder and harmful drinking

Poorer engagement : HK data

Service use past year	Any CMD ^a				Psychotic disorder			
	Age 16-25 (n=78)	Other age ^b (n=686)	χ^2	Sig.	Age 16-25 (n=9)	Other age ^b (n=120)	χ^2	Sig.
	%	%			%	%		
Any mental health service use	15.4	27.2	5.047	.025	66.7	80.8	1.044	.307
Physician	11.5	20.9	3.827	.050		77.5	2.208	.137
Psychiatrist	6.4	14.6	3.956	.047	55.6	75.8	1.808	.179
Non-psychiatric specialist	0.0	1.5	1.154	.283	0.0	0.8	0.076	.783
General practitioner and family physician	5.1	6.0	0.093	.761	0.0	1.7	0.152	.696
Non-physician	12.8	13.4	0.023	.881	11.1	30.8	1.567	.211
Mental health professional ^c	0.0	1.8	1.388	.239	0.0	10.8	1.084	.298
Psychologist	7.7	3.5	3.253	.071	11.1	7.5	0.153	.696
Social worker/counselor	10.3	9.2	0.093	.760	0.0	24.2	2.806	.094
Traditional Chinese Medicine practitioner	1.3	1.9	0.147	.701	0.0	0.8	0.076	.783

Data from HKMMS

Optimising Primary and Specialist Care

2.3.50 Child and adolescent mental health services are often provided through specialist care at the moment, resulting in inefficient use of resources and long waiting time for such services. Enhancing the capacity of specialist care alone cannot address the problems arising from increasing demand. There is a need to establish an integrated system where complex specialist care is supported by primary care services that facilitate preventive care, early detection, timely treatment and continuous care. Capacity and manpower at different tiers of the service delivery model need to be strengthened. The use of community resources should also be optimised to organise more structured and evidence-based programmes so as to enhance the support services at the community level. If the mental health needs of children and adolescents can be shared out among specialist and non-specialist services, it will help ease the bottleneck at specialist services. After all, mental health care ought to premise primarily on self-care management and community care, to be supported by hospitals only as a last resort.

Capacity Building of Carers and Service Providers

2.3.51 Mental health services for children and adolescents include a wide spectrum of prevention, assessment, intervention, counselling, consultation, rehabilitation and referral services given by multiple agencies. Although the capacity of service providers has expanded significantly over the years, it is still busy catching up with rising demand for such services, due in part to better awareness and diagnostic tools.

2.3.52 As the Government continues to invest in child and adolescent mental health services, it is important to promote efficient use of resources by promulgating evidence-based service models among service providers so that the effectiveness of intervention programmes can be assessed and their quality be assured. There is also a need to strengthen training in child and adolescent mental health by incorporating foundation knowledge and care approaches into the training or professional development curriculum of primary care physicians (such as paediatricians, family doctors, etc.), nurses, as well as allied health and social care professionals. As children's mental health and emotional well-being is nurtured primarily in family and in school, capacity building of parents and teachers is of ultimate importance such that they are empowered with the necessary skills to take proper care of them and support them through the early years of life.

Figure 2.14 Gaps in Mental Health Services for Children and Adolescents

Figure 3.8 illustrates the life-course approach adopted in the provision of mental health services for children and adolescents. Along the care pathway, there are areas requiring further work. The identified service gaps and corresponding suggested improvements are summarised as follows -

Service Gaps	Bridging the Gaps
<p>1. Pre-school Age - The attachment relationship with parents and carers is important to a child's mental health development. Parenting education is not widely promoted in the child care and education sector. Not all parents with parenting difficulties would or could seek help from health services such as attending the parenting programmes offered by MCHCs. At-risk mothers are identified during antenatal and post-natal health visits, but there are still some at-risk mothers/families who may not be reached by nor willing to accept the existing services provided under the CCDS. In this regard, some children from at-risk and disadvantaged families (pregnant women with substance abuse, parents with known mental illness, families of domestic violence, etc) are not provided with the needed support. It is sometimes difficult to assess the parenting capacity of at-risk parents and their children may be exposed to unnecessary risks. Service capacity (e.g. secondary care, rehabilitation services, etc.) is not catching up with rising demand. There is room for improvement in coordination among service providers. There is also a need to enhance primary care, social and education professionals' knowledge and skills in identifying and managing children with mental health/developmental problems.</p>	<p>➤ Pre-school Age – Collaborative effort from healthcare, social and education sectors is required to systematically enhance parenting knowledge and skills, strengthen child-carer relationships, address behavioural and emotional problems in infants and children, promote family mental health, as well as to enhance day care, family and parenting support. These will improve the mental health of children and prevent or ameliorate early symptoms of mental health difficulties. More effective intervention programmes and better monitoring system should be put in place to provide timely intervention to children from at-risk/disadvantaged families. There is a need to develop a framework to better assess the parenting capacity and for further research on effective intervention strategies. The capacity of secondary care and rehabilitation services should be enhanced, and structured training should be provided to frontline healthcare, social and educational professionals to equip them with the skills and knowledge in identifying and managing children with mental health problems. A clearer pathway of referral and a more systematic platform for cross-sectoral coordination among service providers should be put in place.</p>

Figure 2.14 (Cont'd)

Service Gaps	Bridging the Gaps
<p>2. Primary School Age - Teachers are in need of more knowledge on different kinds of mental illness which have unique signs and symptoms and require specialised treatment and intervention. Some parents are still not yet prepared to disclose information regarding their children's medical conditions to schools, making it difficult for schools to monitor the progress of students and provide timely and appropriate support. Under the competitive quotations exercises of the Comprehensive Student Guidance Service, service continuity cannot be ensured and thus has impact on the smooth collaboration among social workers, school personnel and NGOs in the community. There is inadequate capacity in secondary care to support children with mental health problems. Community-based services provided by NGOs are limited due to high demand. The waiting time for secondary care and community support services is long. In terms of service delivery, there is little consensus on the best service delivery model in providing effective and uniform care to children with mental health problems. Coordination among service providers is inadequate.</p> <p>3. Adolescence - Service gaps for this age group are similar to gaps in services for those at primary school age in respect of the capacity of schools, secondary care, community-based support services and coordination among service providers. The needs of those who are not in education (some may be in vocational training/employment and some not in education and employment) may have been neglected.</p>	<p>➤ Primary School Age - More seminars delivered by medical professionals to teachers should be provided in order to enhance their knowledge and skills to identify and manage students with mental health problems. There may be a need to enhance information exchange between parents, schools and psychiatrists of HA so that any mental/developmental problems in children could be better identified and followed up. There may also be a need to promote greater understanding on mental health, reduce stigma and encourage more positive help-seeking behaviour in parents and schools. More education to promote physical and mental health may help. One of the ways may be to revisit the existing curriculum and/or teaching resources with a view to strengthening mental health education. The capacity and service continuity of secondary care and community-based support should be enhanced. It is necessary to promulgate an effective service model with reasonable manpower set upto provide quality care to students with mental health problems. We also need to enhance communication between service providers so that the services can be provided in a more coordinated manner.</p> <p>➤ Adolescence - The social and vocational needs of adolescents who are not in education should be more properly addressed. There may be a need to strengthen outreach and social services with a view to identifying more at-risk adolescents in the community (especially for those who are not in education and/or employment).</p>

Figure 2.14 (Cont'd)

Service Gaps	Bridging the Gaps
<p>4. Transition (from Pre-schoolers to School Children and from Adolescents to Adults) - There is little coordination of services from one stage to another, including coordination of support services and subsidies for children from pre-school age to school age. Young people may find the shift from one stage to another too abrupt. There may be some discontinuity of services because of age cut-off and institution-based service boundaries.</p> <p>5. Youth - Youth begins with adolescence and ends with early adulthood (roughly aged between 15 and 25, Keniston, 1970). Behavioural problems, interpersonal sensitivities, relationship difficulties, academic failure and substance abuse are common risk factors of this group of young people for mental disorders. Early manifestations of mental disorders intermingle with other transient psychological upheavals, making screening more challenging. Conventional services often get entrenched in a rigid way of thinking about and responding to behaviour in youths.</p>	<p>➤ Transition (from Pre-schoolers to School Children and from Adolescents to Adults) - There is a need to review the transition of support services and subsidies for children from pre-school to school age. There is also a need to review the developmental needs of young people who enter adulthood and provide them with age appropriate services (e.g. education to vocational training/employment, housing, etc.).</p> <p>➤ Youth - There is a need to develop a youth-friendly engagement platform that could cater for young people's needs and build up the capacity of teachers and youth workers for early identification and intervention of young people at high-risk states or with mental disorders. Figure 2.15 illustrates the idea of how such platform could work.</p>

Figure 2.15 Setting up a youth-friendly platform for mental health services

Figure 2.15 illustrates the four core functions of a youth-friendly platform targeting at different aspects of youth mental health needs: -

- (1) Provision of education programmes to raise public awareness specifically towards youth mental health: By educating youths and their families about mental well-being, mental disorders and the importance of timely help-seeking, capacity of the youths and their families for identifying emerging mental health problems could be enhanced.
- (2) Establishment of a community network to facilitate help-seeking by youths with mental health problems: The platform could work with schools and colleges to provide community youth programmes and enhance the training of youth workers in delivering youth-friendly services.
- (3) Provision of an engagement platform for common mental health issues such as mood disorders, anxiety disorders, psychosis and substance abuse found in young people: Early intervention and support services could be provided through the platform for youths at risk, who have not yet developed major mental health problems.
- (4) Delivery of early intervention services to youths who are suffering from, or at risk of, mental illness such as psychosis: Attention to incipient psychotic disorders may reduce the risks and burdens of full-blown development of psychosis in young people. Consideration could be given to integrate such service with the existing EASY programme so as to provide early intervention/referral services for this group of young people.

The platform may be supported by a team of mental health professionals specialising in youth mental health (e.g. occupational therapists, social workers, psychiatrists, etc.) to enhance youth mental health services for mood disorders, anxiety disorders, and substance abuse, and adopt a more preventative approach in the community setting.

The platform should provide a youth-friendly environment and be accessible by youths who would feel complacent to drop in and spend time without pressure that they are committed to a “consultation”. While they are there, workers can engage them in a more flexible and unpressurised manner. There should be space for a range of leisure activities and social gathering, as well as space for counselling, medical and psychological consultation. Physical setting could be integrated with an online platform.

2.4 A Stepped Care Model for Children and Adolescents with Mental Health Problems

2.4.1 While under the existing approach, parents, schools, social workers as well as healthcare professionals all seek to identify as early as possible any mental/developmental disorders that a child may have developed and refer them to the appropriate services, the gaps identified in the previous chapter suggest that children and adolescents with mental health problems may not always have ready access to the services they require. To improve the current situation, the Expert Group has examined the current state of mental health services provided to these children and adolescents.

2.4.2 The Expert Group sees a need to refine the service model to make it more responsive to the needs of children and adolescents. The model should seek to eliminate bottlenecks, align and integrate services provided by medical, social and education sectors, while making more efficient use of resources and expertise in the public, subvented and private sectors. Along the continuum of care there should be intervention options of varying intensity that are linked to the specific needs of children or adolescents who are displaying mental/developmental problems. To ensure that prevention and intervention are provided in a timely manner, a clear process for making assessment, referrals, intervention and evaluation should also be agreed by service providers. Figure 2.16 gives us the idea of the major principles of care for children and adolescents with mental health problems.

Figure 2.16 Major Principles of Care for Children and Adolescents with Mental Health Problems

In developing the service model of care for children and adolescents with mental health problems, the following principles have been taken into account. These principles cover the needs of children and adolescents with mental health problems as well as their carers.

Comprehensive and child-centred services

- Children and adolescents should have access to a comprehensive array of services that address their physical, cognitive, emotional, behavioural and social needs in order to promote positive mental health. The services should take a holistic view of the child in the various contexts including the family, school and community. The services should be developmentally appropriate and built on the strengths of the child, taking into account his/her needs in various contexts.

Prevention, early detection and intervention

- The services should support promotion of early child development and mental well-being, as well as early detection and intervention for children with mental health needs to maximise the likelihood of positive outcomes.

Integrated service with the involvement of family and school

- The mental health needs of children and adolescents must be responded to in a manner that takes account of the key people in their lives. Home and school are the primary places where children encounter positive adult and peer role models, as well as develop and foster social skills that are essential to shaping their mental health and well-being. The involvement of family and school in mental health services integrated with the support of social and health sectors may help promotion of well-being and enhance management of mental health issues.

Smooth service transition

- Smooth service transition from one stage to another (e.g. from childhood to adolescence to adulthood) should be ensured by addressing the age-specific needs of children and young people with ongoing mental health needs. A smooth transition into the adult service system when they reach the age for adult services is particularly important as these young people would face a totally different set of challenges in education, training and employment. Adequate support should be given to them to help them gain dependency.

Principles of Care

2.4.3 Children and adolescents with mental health problems often require an array of services. A child-centred approach should be adopted so that the services can be built around the needs of a child. While specialist services should give priority to the most seriously disturbed children and those most at risk of developing severe disturbance, there is also a need to give early support to children and adolescents with less severe levels of disturbance by providing them with consultation, counselling, education, training and support in the primary care setting. Thus, the services should be comprehensive in coverage and targeted in nature to address the specific needs of a child, with a view to supporting early detection, timely intervention and smooth migration from one developmental stage to another.

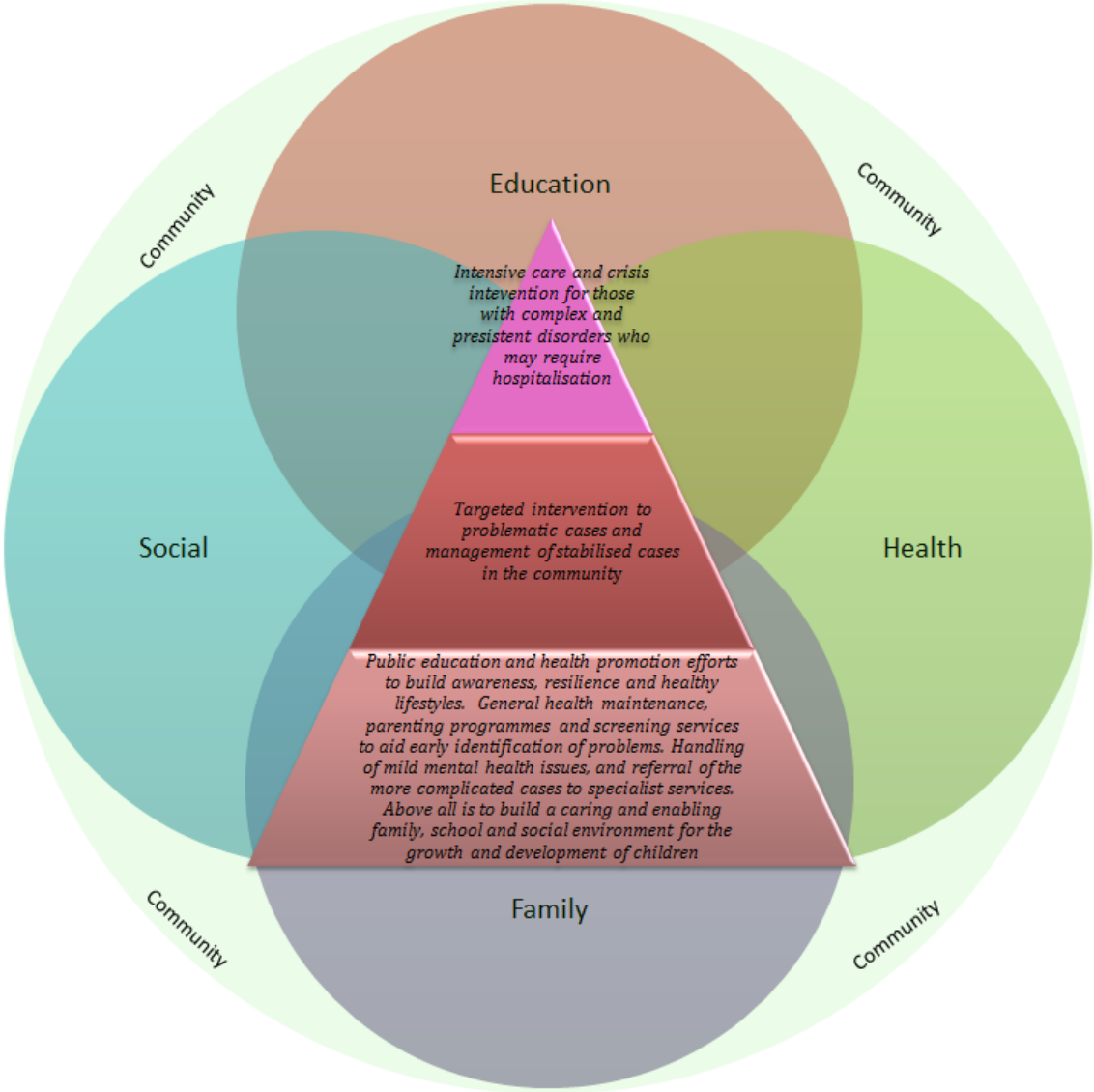
2.4.4 Above all, the Expert Group recognises that children's mental health and well-being is nurtured primarily in the family and later in school. Therefore a key priority of mental health services for children and adolescents is about supporting and enabling parents and educators to enhance children's emotional well-being in partnership with other care professionals in the community. Interventions across different sectors need to help young people have meaningful participation in school and community, build self-esteem and resilience, develop strong emotional intelligence skills and problem-solving ability, as well as avoid risk-taking behaviours.

The Stepped Care Model

2.4.5 With the above principles in mind, the Expert Group recommends the adoption of a three-tier stepped care model to facilitate cross-sectoral and multi-disciplinary collaboration in the delivery of child and adolescent mental health services. The emphasis is on promotion of mental health, as well as prevention, early detection and effective intervention of problems. When a child suffers from a mental illness, a care plan will be drawn up. But equally important is the maintenance and management of the child's conditions, which is more often about adaptation to the environment and long-term care. Multi-sectoral inputs, including those from the health, social and education sectors, as well as from family, are therefore integral to the overall care plan. In view of the multi-facet needs, the tiered model would align these needs to care intervention delivered at appropriate level. With multi-sectoral participation, the stepped care model, which is operated in a dynamic manner, also seeks to remove barriers across professional and service

boundaries by developing more cohesive care pathways and strengthening connections between tiers. The level of professional inputs is determined by professionals with the right skill sets, and care intervention is augmented until an effective and measurable outcome has been achieved. Figures 2.17 and 2.18 illustrate how the proposed model works.

Figure 2.17 Three-Tier Stepped Care Model



Tier 1 – Universal Prevention, Early Detection, Intervention and Mental Health Maintenance

2.4.6 Tier-1 services refer to prevention, early intervention and mental health maintenance strategies that aim to prevent behavioural and emotional problems from developing in children and adolescents. They include public education and health promotion efforts to build awareness, resilience and healthy lifestyles, general health and mental health maintenance, parenting programmes and screening services to aid early identification of problems, handling of mild mental health issues, and referral of the more complicated cases to specialist services. Above all is to build a caring and enabling family, school and social environment for the growth and development of children. Advice, counselling and support are provided to parents by social workers, school teachers, primary care doctors, paediatricians, etc. These professionals are not necessarily trained as specialists in mental health. But they will be supported by specialists through training and supervision so that they are equipped with the necessary skills and knowledge in provision of Tier-1 services to children. Given their close and frequent contacts with the child concerned, it is important that they should be able to formulate care plan and provide appropriate interventions and support for the children and their family. For children and adolescents with relatively complex mental health problems, further support from Tier 2 (e.g. provision of a more elaborated care plan, as well as more structured and targeted intervention) will be solicited.

Tier 2 – Targeted Intervention and Important Linkage between Tier 1 and Tier 3

2.4.7 Tier 2 should serve as a bridge between Tier 1 and Tier 3 to (i) provide more structured and targeted assessment and intervention for relatively complex cases identified by Tier 1, (ii) provide ongoing management and support for children who are attending Tier-3 services and work closely with Tier 3 to ensure smooth transition of care and support services for children with moderate to severe mental health problems.

2.4.8 One of the functions of Tier 2 is to provide more structured assessment for children and young people whose behaviours and/or emotional difficulties are progressively affecting their psychological, social and educational function, and have placed them at risk of developing more complex mental health problems. The aim is to minimise negative impacts and prevent escalation to

more serious problems. After assessment, more elaborated care plan, as well as targeted and structured intervention, should be formulated. Towards this end, professionals in Tier 2 should work closely with those in Tier 1 to equip them with appropriate training and support to develop the skills in delivering interventions and provide appropriate care in the community for those with mental health problems. Intervention in Tier 2 will include medical treatment, social care (such as rehabilitation services and other services to look after the general welfare of the child and the family) and education support. An evidence-based model is the establishment of a school-based platform through which a multi-disciplinary team comprising parents, school personnel, EPs, school social workers and healthcare professionals should be formed to review the progress of each case and adjust the intervention strategies or care plans where necessary. The advantage of the model is to keep treatment and support in the community, reduce disruptions caused to the children and their families by having to attend specialist services, and to help the children to maintain their conditions in familiar environment. Early intervention can also reduce the need for referral to specialist services.

2.4.9 Secondly, the multi-disciplinary team should work closely with Tier 3 to implement, adjust and monitor the overall care plan and progress of children with a view to achieving better psychological, social and school adjustment. In case of deterioration in children's functioning or mental state, Tier-2 professionals could consider if escalation to Tier 3 is required. Vice versa, if children's conditions are stabilised with progress, their cases can be downloaded to Tier 2 to optimise the use of resources in both tiers. Whereas the focus of Tier-1 intervention is on prevention, early detection, timely intervention and mental health maintenance, Tier 2 is the key to ensure that the child will stay in productive education, continue to grow and develop like their peers in families and community, while having their mental health issues and learning disabilities attended to and addressed.

Tier 3 – Specialist Intervention

2.4.10 Specialist intervention is provided to children and adolescents who are experiencing moderate to severe mental health and emotional difficulties which are having a significant impact on daily psychological, social, and educational functioning. They also provide crisis resolution, in-patient and day care services, and residential care to children and adolescents at immediate risk or with very complex or enduring problems who need intensive therapeutic care at the tertiary level. Specific long-term care plan will be formulated by respective healthcare, social and/or education professionals, with intensive and targeted care being provided to meet the complex needs of patients. This tier will work closely with Tier 2 to ensure continuity in care being provided to children and adolescents in need. Partnership between education, health and social services is essential, as disorders of a more complex/serious nature require even more intensive intervention by specialists of the respective field. Medical intervention apart, rehabilitation and long-term care services in the community as well as continuous learning support from schools and employment support from social agencies are equally important to facilitate the child's recovery and re-integration in society.

Figure 2.18 Stepped-care Model - Multi-sectoral Participation

Tier	Sector	Personnel	Roles and functions
Tier 1	Health	<ul style="list-style-type: none"> • General Practitioners • Paediatricians • Family doctors • Nurses 	<p>Healthcare professionals in the primary care settings (e.g. outpatient clinics, family clinics, MCHCs, etc.) are usually the first point of contact when a child needs health advice. Primary health care professionals will help identify early behavioural and emotional problems in children and adolescents, through health maintenance programmes (e.g. developmental surveillance scheme conducted in partnership with parents at MCHCs, etc.) or clinic encounters for other health issues, provide early intervention (e.g. Positive Parenting Programme (Triple-P) and refer them for secondary services when necessary.</p>
	Social	<ul style="list-style-type: none"> • Social workers 	<p>Integrated Children and Youth Services Centres (ICYSCs) provide a wide range of developmental and support services at neighbourhood level to meet the multifarious need of children and youth aged from 6 to 24. This will contribute to the positive development of their mental health. Social workers can help identify those who may have emotional problems and behavioural problems with regard to distress. Young people with less serious problems and distress will be able to draw on support from social workers and peers to relieve their problems such that the conditions will remit without a need for referral to services at the higher levels. More complicated cases may be referred to second tier when needed.</p> <p>65 IFSCs and two ISCs operated by SWD and NGOs over the territory provide a spectrum of preventive, supportive and remedial welfare services to individuals and families in need, including the children and adolescents with mental health problems and their families. Social workers will thoroughly assess the welfare needs of the individuals and families and provide them / refer them for appropriate services.</p>

Tier	Sector	Personnel	Roles and functions
Tier 1	Social (Cont'd)	<ul style="list-style-type: none"> • Social workers 	<p>Early identification and intervention can effectively prevent family problems from deteriorating. As some families in need are reluctant to seek help, IFSCs and ISCs, Family and Child Protective Services Units and Psychiatric Medical Social Service Units have implemented the Family Support Programme. Through telephone calls, home visits and other outreaching services, social workers contact the families with members at risk of domestic violence or mental illness and those with problems of social isolation and refer them to a host of support services. The service units will also recruit and train volunteers, including those with personal experience in overcoming family problems or crises, so that they can contact these families and encourage them to receive appropriate support services with a view to preventing the problems from deteriorating.</p>
	Education	<ul style="list-style-type: none"> • Teachers • Student guidance personnel • School social workers • Educational psychologists 	<p>School-wide promotion on mental health will enhance students' awareness on mental health. Schools also provide an important platform for students to learn problem solving and coping skills. School personnel, including teachers, student guidance personnel, school social workers and educational psychologist will collaborate with professionals in other sectors to help students enhance social/emotional or behavioural adjustment and well-being and will identify those with early signs of mental health difficulties and refer cases to the second tier when needed. This will help reduce the consequences of early mental health difficulties that lead to adverse outcomes. For pre-primary children, teachers will promote parenting, identify and refer children in need for assessment and support services.</p>

Tier	Sector	Personnel	Roles and functions
Tier 2	Health	<ul style="list-style-type: none"> • General Practitioners • Paediatricians • Family doctors • Nurses • Occupational therapists • Speech therapists • Clinical psychologists • Child psychiatrists 	<p>Both primary and secondary healthcare services will be provided to the child/adolescent in need, depending on the nature of support required. At the primary care setting (e.g. outpatient clinics, family clinics, etc.) healthcare professionals with specialised training in mental health will provide consultation to cases referred from Tier 1. If a second opinion is needed, experienced healthcare professionals or specialists will be brought into play to provide further advice to the cases concerned. Training to primary healthcare professionals to enhance their capacities in diagnosis and treatment of mental disorders in children and adolescents would be provided by mental health specialists. Major functions of the health sector are summarised below -</p> <ul style="list-style-type: none"> • Conduct structured assessment and triage; • Work closely with the Team of Tier 2 to formulate comprehensive clinical care plan for individual patient; • Provide expert advice regarding medical support for cases concerned; • Monitor the implementation of the care plan in mental health aspect for respective school-aged children/ adolescents, and refer school-aged children/ adolescents to Tier 1 for mental health maintenance or Tier 3 for intensive medical care if necessary; and • Provide training to primary healthcare and other relevant professionals to enhance their capacities in addressing mental health issues of children and adolescents.
	Social	<ul style="list-style-type: none"> • Social workers 	<p>Apart from treatment of mental problems, the management of a child's conditions and the consideration of his long-term welfare and post-recovery needs are a major part of the care plan. Social workers should work closely together with health and education professionals in Tier 2 to formulate a comprehensive care plan for the child concerned. Major functions of the social sector are summarised below –</p> <ul style="list-style-type: none"> • Work closely with the Team in Tier 2 to provide expert advice regarding social support for cases concerned and formulate a comprehensive care plan on social perspective for the child concerned;

Tier	Sector	Personnel	Roles and functions
Tier 2	Social (cont'd)	<ul style="list-style-type: none"> • Social workers 	<ul style="list-style-type: none"> • Provide family support relating to social welfare aspect and consider their long-term welfare and post-recovery needs to be involved in the care plan. • Monitor the implementation of the care plan in social welfare aspect for respective school-aged children/ adolescents, and adjust the plan to suit their needs; and • Coordinate and work closely with the social workers in the community (e.g. IFSCs, ISCs, ICYSCs, ICCMW, etc.) to identify the high risk families and their children's needs on community social welfare and suitable NGO services.
	Education	<ul style="list-style-type: none"> • Teachers • Student guidance personnel • School social workers • Educational psychologists 	<p>Children and adolescents with mental health problems may need additional support from schools, as they may find it difficult to cope with academic and social demands during their pathway of recovery. Teachers, student guidance personnel, school social workers and educational psychologists will work closely with professionals in other sectors to attend to their problems and needs. Early intervention of mental health problems (e.g. counselling, continuity of support in a caring and familiar environment, etc.) has long-term benefits in turning students away from a path leading to issues such as substance misuse/dependence, isolation, self-neglect. Major functions of the education sector are summarised below –</p> <ul style="list-style-type: none"> • Coordinate the formulation and implementation logistics for the communication platform in the school setting involving cases, parents/guardians and all relevant care professionals (i.e. teachers, school social workers, educational psychologists, healthcare professionals) • Work closely with the Team in Tier 2 to formulate a comprehensive care plan on educational perspective for the child concerned • Work closely with the Team in Tier 2 to implement the care plan in order to provide help to students to enhance social, emotional or behavioural adjustment, educational adjustment and overall well-being. • Monitor the implementation of the care plan in education aspect for respective students, and adjust the plan to suit their needs if necessary.

Tier	Sector	Personnel	Roles and functions
Tier 3	Health	<ul style="list-style-type: none"> • Child psychiatrists • Nurses • Occupational therapists • Speech therapists • Clinical psychologists 	<p>Secondary and tertiary services are provided to children/adolescents with moderate to severe mental disorders, including eating disorders⁵⁴, addictions, schizophrenia, etc. These services include crisis resolution, in-patient and day care services. Multi-disciplinary professionals including child psychiatrists, clinical psychologists, speech therapists, nurses, occupational therapist, etc., will work together to provide treatment in the acute phase and draw up a longer-term care plan (involving professionals from the social and education sectors as well). These children and adolescents may need longer-term therapeutic work that deals with more complex developmental issues, and deeper-seated and long-standing emotional, psychological and mental problems.</p>
	Social	<ul style="list-style-type: none"> • Social workers 	<p>Once a child/adolescent is discharged from hospital, the long-term care of the child/adolescent has to be taken care of by a team of personnel from the health, social and education sectors. Social workers will liaise with the hospital, the school, and the family to ensure a continuity of care is provided to the child.</p>
	Education	<ul style="list-style-type: none"> • Teachers • Student guidance personnel • School social workers • Educational psychologists 	<p>Personnel from the education sector should establish proper and close links with medical and psychiatric services for consultation and referral. Teachers, student guidance personnel, school social workers and educational psychologists will collaborate with professionals in other sectors to help students with mental disorders re-enter school and adapt to school life, in tandem with the medical treatment and rehabilitation requirements. Counselling services and additional resources provided by schools can complement the medical treatment.</p>

⁵⁴ HA delivers mental health service using an integrated and multi-disciplinary approach involving psychiatric doctors, psychiatric nurses, clinical psychologists, medical social workers, and occupational therapists. According to the severity of patients' clinical conditions (including patients with eating disorders), healthcare professionals provide appropriate in-patient, out-patient, day rehabilitation training and community outreach services to patients based on the needs of each case. On average, the number of patients with eating disorders treated in HA's psychiatric specialty was around 400 per year.

Building on Strengths and Bridging the Gaps

2.4.11 In order for the three-tier model to function effectively, it is necessary to build on the services that already exist, recognising their strengths and bridging the gaps in between. As discussed in Section 2.3, healthcare, education and social services are already in place with a range of interventions available. Services are largely accessible to the general public, albeit not being unlimited in capacity. While there is no need to reinvent the wheel when revisiting the current model, there are a few areas requiring further work in order for the model to run more smoothly and effectively.

2.4.12 Overall speaking, professionals of child and adolescent mental health services endeavour to deliver services within their own sector and tier, but there is little communication and collaboration across tiers and across sectors within each tier. Although the need of training is recognised, the variations in perspectives and skills among professionals within each tier mean that not everyone involved in the provision of care is on the same page about what the priorities are. Various programmes are being run and tested at different levels and settings, yet their effectiveness and efficacy are not being evaluated. Sometimes, the programmes themselves may not be evidence-based. As the family, social and education contexts of children and young people have a powerful influence on the onset, expression and remission of developmental and psychiatric problems, working with families, schools, healthcare, social care professionals and communities are indispensable elements (Figure 2.19 discusses the role of families and schools in taking care of children and adolescents with special needs). Yet this is one of the biggest gaps being identified. When needs are not matched with the appropriate levels of intervention, scarce resources will likely go to waste. More specifically, the gaps of each tier are discussed below –

- Tier 1
 - Universal services at this level have limited capacity (in terms of both the skills and time of professionals available) to cater to the needs of the general population.

- Insufficient knowledge on child and adolescent mental health in both services providers and recipients (and also families/parents of service recipients) and stigmatisation are not conducive to help-seeking.
- Tier 2
 - Tier 2 is supposed to function as a “glue” to hold the layers together, but is currently the weakest link among the three tiers due to inadequate coordination.
 - Inadequate support from education, social and family services may add burden to the health system.
 - Inadequate capacity and fragmentation of services have resulted in long waiting time for services.
 - There is a lack of consensus among service providers on service delivery model.
 - Some intervention programmes are scattered, fragmented and lack of quality assurance.
- Tier 3
 - Difficulty of Tier-2 services to cope with demands have resulted in heavy reliance on Tier-3 services; and then come long waiting time for first assessments and long gaps between treatment sessions due to limited resources in Tier 3 in terms of manpower of specialists.
 - There is generally insufficient capacity across all disciplines when Tier-3 professionals are standing in to deliver services at the second tier.

2.4.13 To bridge the gaps, it is of paramount importance to strengthen the foundation of the model. Recognition of the need and effectiveness of the model at the policy level will give proper mandates professionals at each level

to deliver their services. Promoting evidence-based practice and regular evaluation of intervention programmes will ensure the proper use of scarce resources and quality assurance. The provision of adequate training to professionals will ensure that they have the right mix of skills and capacity to deliver the necessary services at each tier. The tier-specific improvements can be summarised as follows –

- Tier 1
 - Universal prevention needs to be expanded, as nothing works better than reducing the incidence of disorders by preventing new cases from developing.
 - Capacity of parents needs to be built (e.g. through parenting programmes), and roles of schools enhanced (e.g. through establishing health promoting schools) to support the development of psychological and social competence of children and young people.
 - Stigma associated with mental health needs to be removed to promote positive help-seeking behaviour.
- Tier 2
 - Tier 2 needs to be adequately staffed and resourced. Service providers and stakeholders have to recognise the importance and contribution of Tier 2 and deploy adequate skilled professionals to carry out the duties. Training has to be provided to improve their proficiency so that they will be confident in providing interventions without the need of seeking additional support of Tier 3 unnecessarily. The professionals will also be in a better position to make downward referrals or dismiss the case when the normal developmental pathway of the child concerned is resumed.
 - School is the primary platform for Tier-2 intervention because it is the place where children and young people spend most of their time. A school-based platform should be established to

bring together education professionals (such as school personnel and EPs), social care professionals (such as school social workers) and healthcare professionals (such as a psychiatrist, a nurse from the attending clinic/hospital) with a view to providing effective intervention. Parents should be involved in the discussion of the problems and care approaches of their children. Regular meetings should be conducted among professionals to review the progress of known cases and triage newly identified cases according to their urgency and severity. Multi-disciplinary interventions are to help children and adolescents resume a normal developmental pathway. The team could assign a school coordinator to liaise the appropriate services across sectors based on the needs of the child concerned. The school-based platform will help integrate healthcare, social and education services which will be delivered in a more cohesive manner and will meet the needs of the children with the right level of intervention.

- Tier 3
 - The highly specialised and intensive services at the top layer will provide timely response to acute and crisis situation, as well as assessment and management of complex cases. Less severe or stabilised cases could be discharged from Tier 3 to continue to receive support in Tier 2. At the same time, specialists in Tier 3 should, in the capacity of advisors or consultants, provide support, training and advice to multi-disciplinary professionals in Tier 2.
 - Tier-3 services also need to be adequately staffed with sufficient manpower and skills mix in order to shorten the waiting time of new cases and the intervals between follow-up appointments, as well as to meet the needs of children with complex mental health problems. It is also essential to build up the capacity in Tier 2 so as to help alleviate the heavy burden of specialists in Tier 3.

Figure 2.19 The Roles of Families and Schools

This chapter has discussed ways to strengthen the three layers such that the stepped care model can work effectively. Putting that in a life-course perspective, from the time a child is born to the time when he leaves school, families and schools have vital roles to play in building resilience in children, promoting social and emotional competence, and helping them fulfil their potential.

Families

Healthy parent-child relationship affects positively the child's emotions and social behaviour, in ways that are difficult to reverse in later life. Primary prevention programmes focusing on building positive parent-child relationship will be much more cost-effective than trying to repair damage at a later stage. Intervention to enhance maternal, paternal and infant mental health and prevent mental problems will help support parenting, family functioning and enhance parent-child relationship. It will also prevent attachment problems. Programmes which promote resilience in children help them do well in spite of adversity. Factors which strengthen resilience include family harmony and healthy relationships between parents. For high-risk groups such as teenage parents, drug-dependent parents, parents with known mental disorders, etc., proactive and early intervention such as home visiting or community-based approaches have more sustained effects than reactive interventions. Quality early education cum care in a centre-based day-care setting will provide a nurturing environment for the child when the parents are not yet ready to do so. Parent training and mutual support programmes have also been shown to be effective for enhancing parenting competence, decreasing parenting stress and reducing behavioural problems in children. Parenting information and knowledge for parents of pre-adolescents and adolescents are equally important as adolescence is a period of huge change in physical, psychological (cognitive and emotional) and social development, and poses significant challenges to the parents in supporting their children through these changes.

Figure 2.19 The Roles of Families and Schools (Cont'd)

Schools

Schools are not just a place for children and young people to receive education, but also a place for building their emotional and social competence. Promoting mental health from the early days of school therefore has social benefits that include better educational attainment and work success, greater social cohesion and a lower dependency on the welfare system. Implementing health promoting schools will provide an environment conducive to the development of mental well-being of children. Schools also play an important role in the early identification of emotional problems, as well as learning difficulties, which can themselves lead to emotional and conduct problems. It is therefore necessary for education and social care professionals working in schools to be suitably trained to provide early help for students who are beginning to show signs of mental health difficulties. To help vulnerable children to cope with a range of issues that include family-child relationship, family problems, illness, stress, anxiety, as well as learning disabilities; it is important to construct a communication platform in the school setting to involve parents/guardians and all relevant care professionals (i.e. teachers, school social workers, educational psychologists, healthcare professionals) in the formulation of care approaches and to coordinate all necessary services for cases in need.

Figure 2.20 Health Promoting School

Health Promoting School, developed by the WHO in the late 1980s, is an approach where the whole school community works together to address the health and well-being of students, staff and their community. Under the health promoting school approach, schools include health and well-being in their planning and review processes, teaching strategies, curriculum and assessment activities.

According to WHO, health promoting schools focus on:

- Caring for oneself and others;
- Making healthy decisions and taking control over life's circumstances;
- Creating conditions that are conducive to health (through policies, services, physical / social conditions);
- Building capacities for peace, shelter, education, food, income, a stable ecosystem, equity, social justice, sustainable development;
- Preventing leading causes of death, disease and disability: helminths, tobacco use, HIV/AIDS, sedentary lifestyle, drugs and alcohol, violence and injuries, unhealthy nutrition; and
- Influencing health-related behaviours: knowledge, beliefs, skills, attitudes, values, support.

Encompassed in the health promoting school concept is the promotion of mental well-being. Other than developing a safe and supportive school environment, schools will also increase awareness of mental health and well-being, as well as enhance social and emotional competence of students. Schools will also identify mental health concerns early, and develop strong pastoral care system, identify health and social programmes that support students' mental health including drug and alcohol programmes, counselling and guidance, peer support, etc.

2.5 Recommendations and Way Forward

2.5.1 Child and adolescent mental health is an essential part of overall health. Children and adolescents exposed to risk factors (e.g. with parents on illicit drugs, victims of child abuse/domestic violence, etc.) are prone to developing mental health problems. Once such problems are developed, there would be lifelong impacts on their mental well-being even after they have entered adulthood. Therefore, it is the responsibility of parents and society to provide a conducive environment for children to grow, develop and flourish. It is also equally important for frontline professionals (such as teachers at schools) to assume a gatekeeping role and help detect vulnerable cases to facilitate early intervention. In short, to improve the mental well-being of children and adolescents, there are needs to promote physical health as well as mental health, prevent mental health problems at early childhood, and provide early identification, with timely and effective treatment to those having developed mental illness.

2.5.2 Mental health problems in children and adolescents may manifest as difficulties or disabilities in their capacity for learning and play, emotional development and relationships with others. They may arise from any number of combinations of biogenetic and physical or social environmental factors, notably in the family and school. Exposure to risk and protective factors in the family, school and community will shape a child's development and affect his/her life chance of developing mental problems. Responsible adults in these settings play an indispensable and complementary role to medical intervention. Gatekeepers, such as teachers at schools, having recognised that children and adolescents are passive in help-seeking and the cause of the problems may be originated from families/parents should take a proactive role in detecting vulnerable cases for early intervention. The Expert Group therefore wishes to point out that medical intervention alone cannot help put children and adolescents with mental health problems back to the normal developmental pathway. The discussions and recommendations in the report have a focus not only on strengthening the services, but also encouraging and supporting the building of capacities and skills of responsible adults (including parents, carers, childcare workers, teachers and school social workers) in settings where children are nurtured.

2.5.3 With the above in mind, the Expert Group considers that the existing services, while not lacking in terms of breadth and coverage, should be consolidated and strengthened through better coordination and/or integration of services, joint capacity building for professionals of different sectors and disciplines involved in providing child and adolescent services, and closer collaboration with parents and the wider community.

Recommendations

2.5.4 With reference to the care models discussed in the previous chapter, the Expert Group has put forward the following recommendations –

Research and Studies

Monitoring of Mental Health Status

1. *Epidemiological studies should be conducted on a regular basis to understand the state of mental health of the population, and local prevalence of child and adolescent mental health problems in particular. This will help inform the formulation of appropriate prevention strategies and the planning of suitable intervention programmes for those with mental health issues.*

Research and Development of Intervention Programmes

2. *Research and development of various intervention programmes (e.g. parent training and support programmes, rehabilitation and social support programmes, nurse-family partnership programme, infant mental health service, etc.) as well as conduct of efficacy studies on these programmes should be encouraged and facilitated so as to enable service providers to apply applicable and evidence-based intervention programmes locally.*

Education and Promotion

- 3. Territory-wide and targeted public education campaigns should be launched and efforts sustained to enhance the awareness and understanding of the general public and the targeted groups on mental well-being and illness, the importance of self-help (e.g. stress management) skills, availability of help-seeking avenues and community resources, as well as to promote a caring and accommodating environment for people with mental illness.*

Assessment, Intervention and Support

Support to Families

All families

- 4. Noting the importance of parent-child relationship to a child's mental well-being, the practice of positive parenting should be promulgated to all parents with a view to enhancing the emotional and social competence of children. To fill a current gap, parenting programmes for parents with pre-adolescents and adolescents should be developed and provided to parents through schools, community centres and the Internet⁵⁵.*

Families in need

- 5. Evidence-based and targeted programmes, which can be adopted locally, should be made easily accessible by parents of children and adolescents in need (for example, those encounter difficulties in parenting or managing child behaviours). These programmes would aim to enhance child mental well-being through appropriate management of child behaviours. Consideration should be given to strengthening Parents/Relatives Resource Centres with a view to providing more targeted support and effective training to parents through which they can be equipped to take care of their children with special needs.*

⁵⁵ Currently, information on parenting children aged 6 or below is available through the website of the Family Health Service of the Department of Health.

6. *Primary prevention and early intervention programmes targeting at-risk groups such as at-risk pregnant women, teenage parents, mothers with postnatal depression, families with psychosocial needs, and pre-primary children with health, developmental and behavioural problems who are identified through the CCDS should be strengthened in order that the physical and mental health outcomes of both parents and children can be improved. Instead of adopting a family-based intervention approach, current services for teenage parents, those on illicit drugs or with severe mental disorders tend to focus more on the well-being of the mother. While protocol on assessing parenting capacity is being developed under CCDS for children under six, more measures to identify needs for facilitating early intervention for strengthening quality of care to children in accordance with their developmental needs are being developed. Consideration should be given to explore ways of strengthening the CCDS in terms of resources and programme effectiveness.*
7. *A safe and nurturing social environment along with optimal nutrition during early years have strong and long-term impact on the mental and physical health of the children. For families (for example, parents with psychosis, those on illicit drugs, etc.) that cannot provide optimal and responsive care to their infants and children, overseas studies show that centre-based and high-quality education-cum-care service is effective in facilitating better mental health development. Research and study of the applicability of similar programmes locally should be considered.*

Timely Identification and Intervention of Pre-school Children with special needs

8. *It was important to provide timely intervention on site in the school setting once special needs (e.g. relating to developmental, educational, physical and behavioural concerns) in pre-school children were identified. To enable early identification and intervention, support provided to kindergarten teachers with a view to enhancing their knowledge and skills in catering for the diversity of needs of pre-school children and identifying those at risk should be strengthened. Consideration should be given to enhancing the capacity of professionals (e.g. EPs) to organise more structured training activities and develop more teaching resources for kindergarten teachers so that the kindergartens are better equipped to cater for the diverse needs of pre-school children with psycho-social and/or*

behavioural problems and those at risks of developmental problems. Apart from capacity building, kindergarten teachers should be supported by professionals in identification and intervention of pre-school children with special needs.

9. *While the pre-school rehabilitation services have been substantially strengthened, the existing child assessment service under the DH and medical services of the HA should also be reinforced in terms of manpower and capacity in order to facilitate early assessment and timely intervention of children in need. In particular, manpower and resources in the assessment and specialist services require immediate enhancement with a view to reducing the waiting time for these services.*

Support to School-aged Children/Adolescents

10. *Schools are ideal settings for promoting and supporting mental, emotional and social well-being of school-aged children/adolescents and should be well supported to enable their meaningful participation in school programmes. Universal promotion of mental well-being targeting at all school-aged children/adolescents could be further enhanced through health promotion programmes and school curriculum on physical and mental health education that aim to facilitate the adoption of healthy lifestyles (for example, more physical activities and healthy nutrition) and the learning of life skills, with a view to building resilience against adversities in life, enhancing their understanding of mental health issues, increasing their awareness of mental illness, encouraging help-seeking and promoting de-stigmatisation. DH, in collaboration with the EDB and tertiary institutes, should explore the feasibility of extending the health promoting school model promulgated by the WHO to all schools in Hong Kong, with a view to building a more caring and supportive environment where school-aged children /adolescents can learn, grow and flourish.*

11. *More targeted support should be provided to school-aged children/adolescents with special needs, such as those with SEN, behavioural issues and mental illness. More structured training, seminars and talks involving multi-disciplinary professionals from medical, social, and education sectors for teachers should be provided to enhance their knowledge and skills in detecting and handling vulnerable cases with mental health concerns (including cases of mood disorder). Considerations should be given to enhance the capacity of primary care doctors and paediatricians who can work with other stakeholders in Tier 1 for the prevention, early detection and intervention, and mental health maintenance of children and adolescents with mental health needs. Considerations should also be given to enhance the capacity of multi-disciplinary professional teams in Tier 2 and Tier 3 which can work closely with Tier 1 to ensure continuity of care being provided to children and adolescents in need.*

12. *Multi-disciplinary intervention approach involving parents, teachers, school social workers, EPs and healthcare professionals should be enhanced to strengthen mental health support services at school. This could be achieved by establishing a school-based platform to bring together these professionals and stakeholders to monitor and support children with mental health needs. It is recommended to pilot this school-based model through collaborations of EDB, SWD and HA by bringing medical professionals to work with school and social care professionals at schools with a view to testing its effectiveness in enhancing the expertise and capacity at school and family support.*

13. *A three-year Pilot Project on Special Educational Needs Coordinators (SENCOs) funded by the CCF from the 2015/16 school year has been launched to provide a cash grant to public sector ordinary primary and secondary schools to arrange a designated teacher to coordinate matters relating to SEN support. It is noted that EDB has appointed consultants to evaluate the effectiveness of the project and to provide training for the SENCOs. EDB should consider the way forward having regard to the outcome of the project.*

Support to Youths in the Community

14. *To encourage help-seeking by youths who encounter, or at risk of, mental health problems, establishment of a youth-friendly platforms and provision of tailor-made services for youths in need (e.g. consideration of providing temporary accommodation designated for youths) could be considered. While youth in the community such as school dropouts should be closely monitored with necessary support and outreach services, existing local platforms for youth work could be made use of to provide youth-friendly support in the community. The platforms could serve the functions of promoting mental well-being of youths, training practitioners in handling mental health cases, facilitating early detection of mental disorders and high risk states, providing intervention programmes to address common mental health needs, arranging referrals to mental health services, etc. Consideration could also be given to integrate the services provided at the youth-friendly platforms with the EASY programme to facilitate early detection and intervention of at-risk or incipient psychotic cases.*

Support for Transitional Periods

15. *To ensure a smooth transition from pre-school rehabilitation services to school support services, support should be provided to the families of children with special needs to facilitate them to access relevant services for their children during the transitional period.*
16. *Special attention should be given to the mental health needs of adolescents as they enter adulthood and to ensure their smooth transition from child and adolescent mental health services to adult mental health and other life-support services. Consideration should be given to explore whether mainstreaming adolescents reaching age 18 (in particular those with developmental disorders) to receive enhanced adult services, or assigning specialised clinics designated for these adolescents, would be effective to facilitate service transition. The feasibility of developing a model for service transition from adolescence to adulthood could be explored.*

17. *When the adolescents reach the age for adulthood, a care plan with assessment of needs should be provided for these adolescents so that they can get the necessary support from the respective adult services including rehabilitation training to support employment to help them face the different set of challenges in education, training and employment. The long-term support for these groups of people throughout their adulthood would need to be separately looked into under another platform.*

Capacity Building

18. *Capacity building is the key to ensure the smooth operation of the 3-tier stepped care model for supporting children and adolescents with mental health issues. Supply should be ensured and training strengthened for care professionals at each and every tier of the model, such that they have the necessary strength and expertise to identify, treat, handle and help those in need through professional training and continuing education. The target groups to be trained include not only parents and teachers, but also healthcare practitioners (including psychiatrists, paediatricians, family doctors, etc.), social care professionals and other caregivers in the community.*

19. *There is a need to build the first tier of the stepped care model and strengthen the second so that effective prevention and gatekeeping at the primary care level (by families, schools as well as health and social care professionals) are in place to prevent unnecessary escalation of cases to the upper layers. Strengthening of training (for example, developmental behavioural paediatric subspecialty) and provision of relevant module under the existing reference framework could be considered to facilitate primary care physicians such as paediatricians and family doctors in the assessment and management of developmental problems in their daily practice. The feasibility of using public-private partnership for downloading suitable HA patients with treatment plans to the private sector could also be explored. Apart from public education, capacity building efforts and public-private partnership recommended above, consideration should be given to the development and promotion of evidence-based parental training/family support programmes and rehabilitation training programmes for reference by service providers outside the Government.*

20. *There is also a need to enhance communication and interface between different layers of the 3-tier model to ensure the provision of holistic and integrated mental health services for those in need, and that each layer is equipped with the appropriate expertise in reasonable strength to provide the right level of care and make the necessary referral. The existing communication and coordination platforms among DH, HA, EDB, SWD and NGOs should be strengthened with a view to articulating a clear pathway and common language of care and support mechanism based on the tiered model. Common monitoring tools and statistical databases should be developed to enable schools and medical/social care institutions to keep track of children and adolescents with developmental or mental health issues as they migrate from childhood to adulthood, in order to provide them with the necessary support and intervention.*

Way Forward

2.5.5 Child and adolescent mental health problems need to be understood in their broader family, school and social context. Promoting the mental health of children and adolescents requires combined and sustained efforts of all sectors and cannot be driven by the Government alone. Actions to promote awareness, enhance care and remove barriers for those in need cut across different policy arenas, service sectors and settings, including family, education, social and medical sectors. Parents need to give their children a favourable environment to support a healthy biopsychosocial development. School is not only a place of education but also a platform for promoting health and well-being in school children. Society as a whole needs to be more accommodating, supportive and non-discriminatory towards mentally troubled and vulnerable children and adolescents. Healthcare professionals in different tiers should have their capacity enhanced and work closely with professionals in other sectors to provide support to the children and adolescents in need.

2.5.6 Children and adolescents are at a stage in life when the future is open to a wide range of possibilities. If problems that arise are caught early, it may be possible to set someone on a path in life that is more positive and less fraught with difficulties. Yet, building awareness and service capacity, as well as removing barriers in service interface, will take time. This report does not mean to prescribe a panacea for all. Rather, it seeks to underline the challenges ahead so that we can get prepared for them.

2.5.7 The observations and recommendations in this report seek to outline a common vision for promoting the mental health of children and adolescents. Instead of being prescriptive in the way about which and how services are to be delivered to mentally troubled and vulnerable children and adolescents, we hope the report can provide a broad roadmap to guide future efforts in promoting the mental health of children and adolescents. We propose to set up a standing advisory committee to continue to follow up on the work relating to the enhancement of mental health services (including the child and adolescent mental health services). It is our belief that with concerted efforts of the community, our next generations will grow up with good health and a better future.

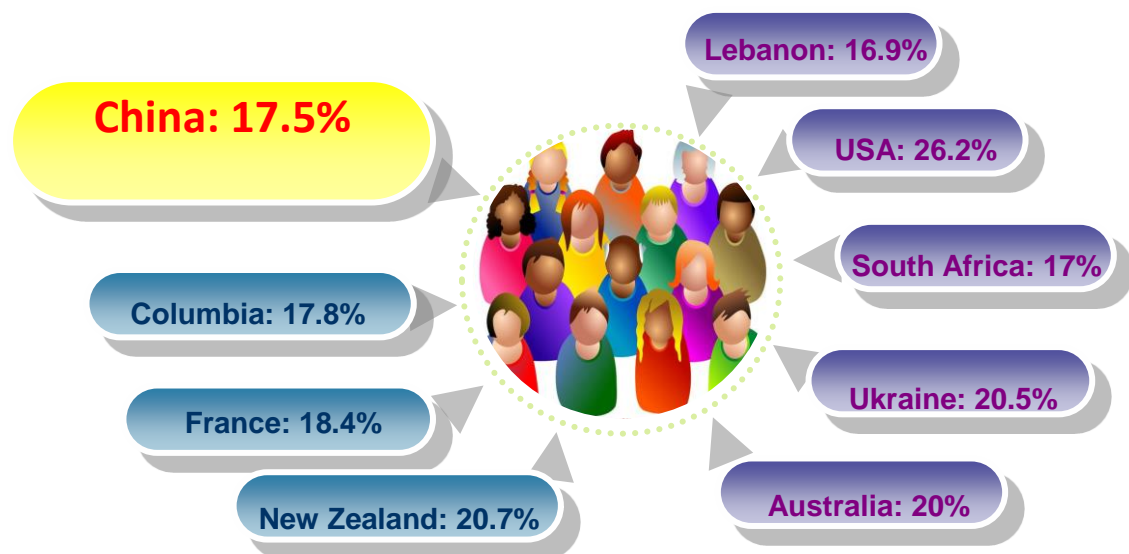
Chapter 3 - Mental Health Services for Adults

3.1 Mental Health Needs of Adults in Hong Kong

Numbers of people with mental disorders

3.1.1 According to the World Health Organization, 450 million people worldwide have a mental or neurological disorder, of who 150 million suffer from depression, 25 million have schizophrenia, and 90 million have a drug or alcohol dependency⁵⁶. Estimates of the number of people in a population with any mental disorder range from between 15% and 25%; and the number of people suffering from severe mental illness ranges between 1% to 3%⁵⁷. In Hong Kong, with a population about 7.3 million, extrapolation from worldwide data would indicate that between 1.1 million to 1.8 million people have a mental disorder and between 70 000 to 220 000 people have severe mental illness.

Figure 3.1: Percentage of people with mental disorder in selected countries⁵⁸:



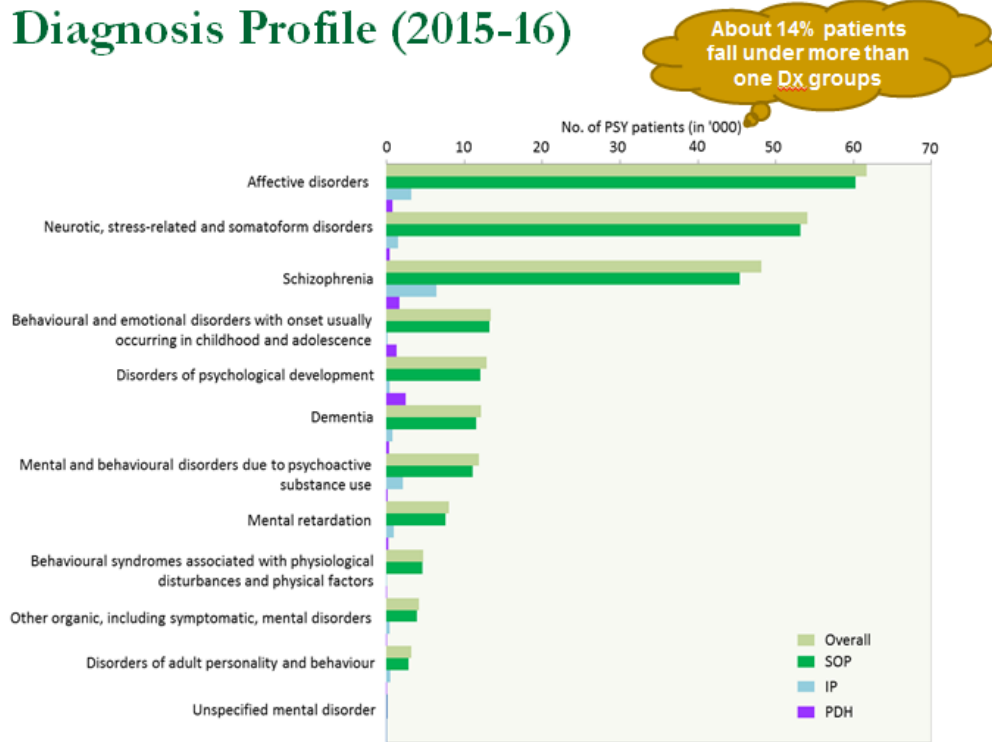
⁵⁶ WHO (2003). *Investing in Mental Health*. (p.8). Geneva.

⁵⁷ Ibid. (p.8)

⁵⁸ WHO (2009). *Addressing Global Mental Health Challenges*. Geneva: Funk, M.

3.1.2 Figure 3.2 below shows the numbers of people in Hong Kong using contact with psychiatric services of HA according to the types of mental disorders:

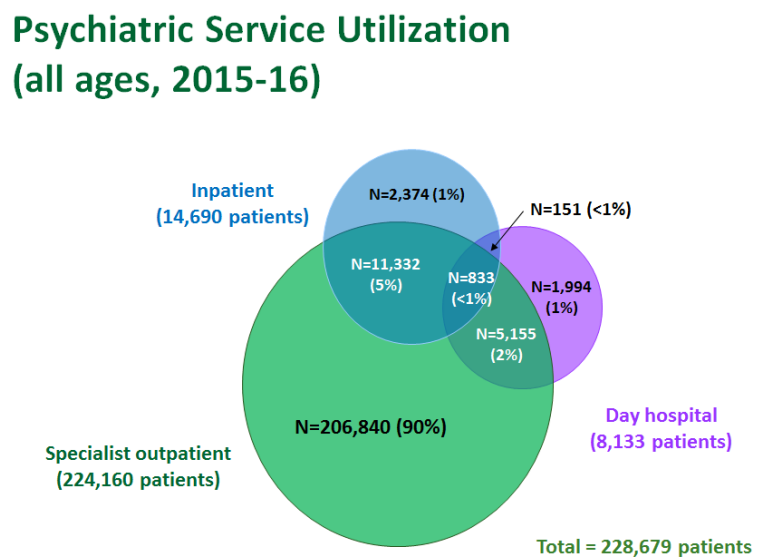
Figure 3.2: Diagnosis Profile in Hong Kong



Source: Statistics & Workforce Planning Department, Division of Strategy & Planning, HA

3.1.3 Figure 3.3 below shows the relative size of the three principal psychiatric services in HA, i.e. in-patient, out-patient and day hospital activities:

Figure 3.3: Psychiatric Service Utilisation



Source: Statistics & Workforce Planning Department, Division of Strategy & Planning, HA

Burden of Mental Illness

3.1.4 Mental disorders now account for the largest proportion of disability in populations worldwide^{59,60}. This is because mental illness is disproportionately suffered by younger people who are statistically likely to live for many years with the illness. WHO measurements of DALYs (Disability Adjusted Life Years)⁶¹ are calculated by:

$$\text{number of years of life lost} + \text{number of years lived with a disability}$$

Measuring illness by DALYs indicates that mental disorders create a significant burden of ill health in populations.

3.1.5 The table below shows the changes in rankings of DALYs from disease or injury between 2004 and 2030, when depressive disorders will be the number 1 disability adjusted illness in the world⁶².

Figure 3.4: Changes in Rankings of DALYs

2004 Disease or injury	As % of total DALYs	Rank	Rank	As % of total DALYs	2030 Disease or injury
Lower respiratory infections	6.2	1	11	1.9	Neonatal infections and other ^a
Diarrhoeal diseases	4.8	2	12	1.9	Prematurity and low birth weight
Unipolar depressive disorders	4.3	3	1	6.2	Unipolar depressive disorders
Ischaemic heart disease	4.1	4	2	5.5	Ischaemic heart disease
HIV/AIDS	3.8	5	3	4.9	Road traffic accidents
Cerebrovascular disease	3.1	6	4	4.3	Cerebrovascular disease
Prematurity and low birth weight	2.9	7	5	3.8	COPD
Birth asphyxia and birth trauma	2.7	8	6	3.2	Lower respiratory infections
Road traffic accidents	2.7	9	7	2.9	Hearing loss, adult onset
Neonatal infections and other ^a	2.7	10	8	2.7	RefRACTIVE errors
COPD	2.0	13	9	2.5	HIV/AIDS
Refractive errors	1.8	14	10	2.3	Diabetes mellitus
Hearing loss, adult onset	1.8	15	13	2.0	COPD
Diabetes mellitus	1.3	19	14	1.8	Refractive errors
			15	1.9	Birth asphyxia and birth trauma
			18	1.6	Diarrhoeal diseases

The Ten Leading Causes of Disability in the World, 2004 & 2030

⁵⁹ WHO (2003). *Investing in Mental Health*. (p.8). Geneva.

⁶⁰ Thornicroft, G., & Tansella M. (2004). Components of a modern mental health service: a pragmatic balance of community and hospital care: Overview of systematic evidence. *British Journal of Psychiatry*, 185, 283-290.

⁶¹ Friedli, L., Jenkins, R., McCulloch, A. & Parker, C. (2002). *Developing a National Mental Health Policy*. (pp. 15-22). UK: Psychology Press.

⁶² WHO (2008). *The global burden of disease: 2004 update*. (p. 51). Geneva.

In recent years, the economic burden of mental illness, as well as the disability burden, has been recognised. In a major study published in 2008, ‘Paying the Price: the cost of mental health care in England to 2026’, the King’s Fund, the influential London-based independent health agency, called for “a sustained effort to support people with mental health needs of working age who are not in employment to return to work” and made the economic case for investing in all forms of mental illness⁶³.

3.2 Mental Health Services for Adults

3.2.1 HA is the major specialist service provider for people with mental disorders in Hong Kong. It provides a spectrum of services ranging from in-patient facilities, day hospitals, and specialist out-patient clinics to community outreach services. HA currently takes care of nearly 150 000 patients with mental illness who are aged between 18 and 64. Most of them are suffering from SMI (30%, such as schizophrenia) and CMD (60%, such as mood disorders and stress-related disorders). Patients with severe or complex mental health needs are provided with multi-disciplinary and intensive specialist care in appropriate hospital settings, whereas those less so including persons with CMD will receive specialist-supported care in the community including primary care settings.

3.2.2 In recent years, HA has been under enormous pressure to meet the increasing demand for specialist mental health services. This growing demand could be due to better awareness and detection of mental health problems, inadequate support from primary care and changes in the socio-economic environment. Therefore, in planning its adult mental health services, HA places special emphasis on early intervention and assertive treatment to minimise the risk of relapse and hospitalisation.

3.2.3 HA has been adopting an integrated and multi-disciplinary approach in delivering psychiatric services to support patients with mental health problems. The multi-disciplinary psychiatric teams of HA comprising healthcare practitioners in various disciplines, involving doctors, psychiatric nurses, clinical psychologists, occupational therapists and medical social workers, etc., provide comprehensive and continuous medical support to psychiatric patients, including

⁶³ McCrone, P. Dhanasiri, S. Patel, A. Knapp, M. Lawton-Smith, S. (2008) *Paying the Price: the cost of mental health care in England to 2026*. London: King’s Fund, xxi

in-patient care, SOP services, day training and community support services. HA also provides community support to psychiatric patients through collaboration and cooperation with SWD, NGOs and other stakeholders in the community.

In-patient services

3.2.4 The number of people treated as in-patients in HA's psychiatric units was about 14 500 in 2015. Most in-patients suffer from SMI such as schizophrenia. Apart from meeting the needs of patients with an acute illness, in-patient beds also serve the needs of extended care patients with complex needs and require a longer period of rehabilitation in the hospital. Through the development of different community programmes, there is less need for beds. The average occupancy rate of in-patient beds has remained to be around 75% in recent years.

SOP Services

3.2.5 SOP care in the public mental health service is one of the most important pillars of psychiatric treatment. The out-patient clinics provide the main bulk of ambulatory care for patients with both severe mental illness and common mental disorders and serves as a major entry point for new patients into the mental health care system. It is a place where both acute management and maintenance of stabilised patients occurs. There were around 808 000 out-patient attendances in 2015-16. The number of attendances has increased by about 7% as compared with the number in 2011-12.

Psychiatric Day Hospitals

3.2.6 Psychiatric day hospitals provide a range of treatment and rehabilitation to patients who attend for a number of hours each week. This form of treatment conforms to the current trend of provision of psychiatric care which advocates that care should take place in a less restrictive environment. HA currently provides about 900 psychiatric day hospital places. The workload at day hospitals has remained fairly constant over the years.

Community Services

3.2.7 Community service is the third major component of mental health services. As HA continues to rehabilitate and integrate patients into the community and downsizing of psychiatric hospitals continues, this component will play an increasingly important role. HA now operates cluster-based community psychiatric services throughout Hong Kong.

3.3 Community Mental Health Support Services for Adults

Medical Social Services

3.3.1 MSWs of SWD are stationed in the psychiatric hospitals and specialist out-patient clinics of the HA to provide timely psycho-social intervention as well as financial and housing assistance for mentally ill patients, ex-mentally ill persons, and their families, with a view to helping them cope with or solve their emotional, daily living and family problems arising from mental illnesses and facilitating their rehabilitation and re-integration into society. In addition, while medical and allied health professionals assist these patients in formulating discharge plans, MSWs will provide professional advice from social work perspective, and make referrals for needy patients and their families to apply for rehabilitation and other community support services.

Integrated Community Centres for Mental Wellness

3.3.2 To strengthen community support for ex-mentally ill persons, persons with suspected mental health problems and their families/carers, SWD has set up 24 ICCMWs across the territory since October 2010 to provide timely “district-based” one-stop community mental health support services, including casework counselling, occupational therapy, outreaching services, day training, consultation services, social and recreational activities, public education activities, and referral of needy cases to the HA for assessment and treatment. The Government continues to increase resources for enhancing the services of the ICCMWs, with a view to providing more intensive counselling and support services for ex-mentally ill persons and their families/carers, thereby relieving the stress on their families/carers and reinforcing the mutual help networks of ex-mentally ill persons. SWD’s recurrent provision for the ICCMWs has increased from \$135 million upon commencement of service in 2010 to over

\$303 million (estimated expenditure) in 2016-17. As at December 2016, the ICCMWs provided services for more than 59 000 ex-mentally ill persons and persons with suspected mental health problems.

Pilot Project on Peer Support Service

3.3.3 With funding from the Lotteries Fund, SWD commenced a two-year Pilot Project on Peer Support Service in Community Psychiatric Service Units (Pilot Project) in March 2016. Under the Pilot Project, 11 ICCMW operators are responsible for providing training services to equip suitable ex-mentally ill persons to serve as peer supporters, who will then offer emotional and recovery support for ex-mentally ill persons in need. As at the end of December 2016, a total of 50 full-time or part-time peer supporters were employed by ICCMWs, half-way houses or vocational rehabilitation units to provide peer support service.

Parents / Relatives Resource Centre for Ex-mentally Ill Persons

3.3.4 The Parents / Relatives Resource Centre for Ex-mentally Ill Persons operated by NGO under the subvention of SWD is set up to provide families and relatives of ex-mentally ill persons with emotional support and advice, in order to enhance their acceptance of their relatives with mental illness, and strengthening their resources and ability to take care of the ex-mentally ill persons at home. In 2015-16, the subvented Parents / Relatives Resource Centre for Ex-mentally Ill Persons was granted additional resources to recruit more social workers to bolster support for ex-mentally ill persons as well as their families and relatives.

Residential Care Services

3.3.5 SWD has been providing various residential care services for ex-mentally ill persons through subvented NGOs, including long stay care homes, half-way houses and supported hostels. Long stay care homes provide discharged chronic mental patients with long-term residential care and active maintenance services; half-way houses provide ex-mentally ill persons with transitional community rehabilitation service in preparation for their re-integration into the community; supported hostels provide group home living for ex-mentally ill persons who can live semi-independently with a fair amount of assistance from hostel staff in daily activities. As at December 2016, there was 3 221 subvented

residential care places for ex-mentally ill persons and a total of 485 planned places will be provided in the coming five years.

Day Training and Vocational Rehabilitation Services

3.3.6 To assist ex-mentally ill persons in improving their social adjustment capabilities and enhancing their social and vocational skills, SWD provides through subvented NGOs sheltered workshops, supported employment service, integrated vocational rehabilitation services centres, On the Job Training Programme for People with Disabilities, Sunnyway - On the Job Training Programme for Young People with Disabilities, “Enhancing Employment of People with Disabilities through Small Enterprise” Project to help persons with disabilities, including ex-mentally ill persons, seek employment in the open market. As at December 2016, there was 12 587 subvented vocational rehabilitation places and a total of about 1 200 planned places will be provided in the coming five years.

3.4 Review on Mental Health Services for Adults

3.4.1 Recognising the increasing burden of mental illness, the Review Committee has adopted a life-course approach to study the existing policy on mental health with a view to mapping out the future direction for development of mental health services in Hong Kong. For adult psychiatric patients, the Review Committee has identified three areas, namely services for patients with SMI, patients with CMD and patients with learning disability for further enhancement having regard to changing needs of the community and resource availability.

3.5 Progress Updates on Enhanced Services

Patients with SMI

3.5.1 For patients suffering from SMI, HA provides a combination of in-patient, out-patient and community psychiatric services to them depending on treatment needs. Targeted intervention is further introduced through the EASY programme and the Case Management Programme. Medication is improved and medical-social collaboration is also established to provide more integrated support services for patients with SMI.

(a) EASY programme

3.5.2 To facilitate early detection and intervention of psychotic cases, HA has launched the EASY programme since 2001 and further enhanced it in 2011-12 under which multi-disciplinary medical teams at cluster service centres provide referral, assessment and treatment services for patients aged between 15 and 64 for the first three critical years of illness. Public education and promotion efforts are also organised under the Programme to enhance awareness of mental health in the community. About 1 300 patients now receive intensive care under the EASY programme each year.

(b) Case Management Programme

3.5.3 HA has launched the Case Management Programme since 2010 to provide intensive, continuous and personalised support for patients with SMI on needs and risk basis. The programme initially covered three districts and has now been extended to all 18 districts in the territory. Under this programme, suitable patients with SMI would be followed up by a designated case manager who would establish close service relationship with the patient and develop an individual care plan having regard to the patient's needs and risk profile. In addition, the case manager would work closely with various service providers, particularly the ICCMWs which are subsidised by SWD, in providing coordinated support to patients with SMI in the community. As at 31 December 2016, around 15 000 patients with SMI residing in the community benefited from personalised and intensive support provided by case managers according to their needs. Depending on the risk and need profile of individual patients, each case manager takes care of about 40 to 60 patients with SMI at any one time, maintaining a ratio of case manager to patients with SMI at about 1:47 on average.

3.5.4 To further enhance community support for patients with SMI, HA introduced a peer support element into the Case Management Programme in 2015-16. Under this proposal, peer support workers who have rehabilitated from mental illness will be engaged to assist case managers in supporting patients in the recovery process through experience sharing.

3.5.5 The EASY programme and the Case Management Programme have recorded positive outcome since inception. The management of first-episode psychosis through EASY programme has reduced the time between onset of symptoms and interventions, and hence lowered the possibility of future relapse and treatment resistance. By providing ongoing and specialised support to SMI patients, the Case Management Programme has successfully helped many patients re-integrate into society.

(c) Use of new anti-psychotics

3.5.6 Intervention programmes apart, medication plays an important part in controlling symptoms of mental illness and preventing relapse. HA has taken steps to increase the use of newer psychiatric drugs with less disabling side-effects over the years. The number of patients taking newer anti-psychotics has increased by around 65% over the past five years to around 45 000 in 2011-12 to around 75 000 in 2015-16. In 2014-15, HA repositioned all newer generation oral anti-psychotic drugs from the special drug category to the general drug category (except Clozapine due to its side effects) in the HA Drug Formulary so that all these drugs could be prescribed as first-line drugs.

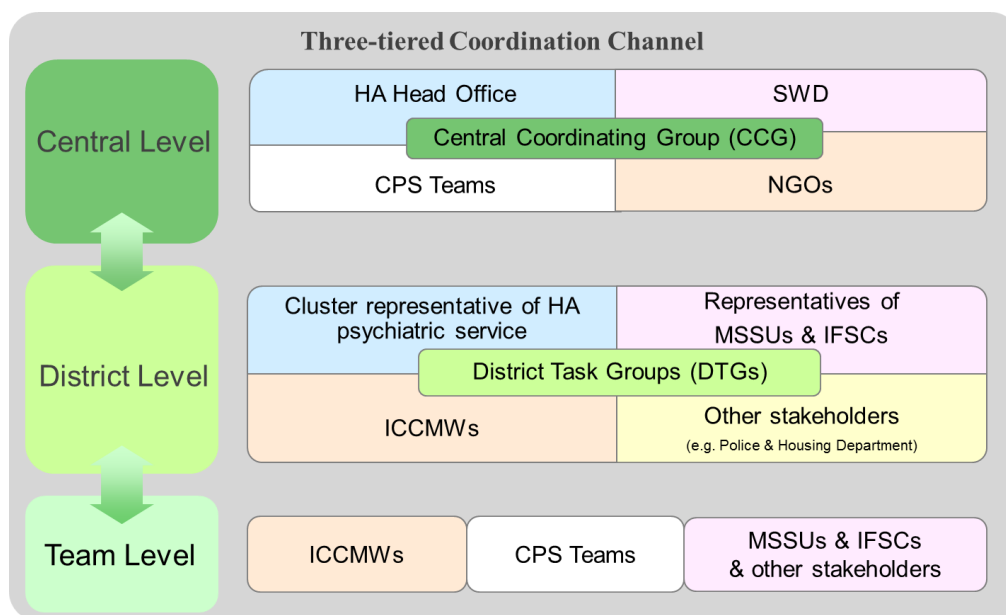
(d) Medical-social collaboration

3.5.7 Patients with mental illness living in the community are supported by a wide range of medical and social services to facilitate their rehabilitation. The effective operation of community mental health services calls for close collaboration among stakeholders from the medical and social care sectors. Following the implementation of the Case Management Programme, a three-tier collaboration platform has been instituted by HA and SWD since 2010 to facilitate cross-sectoral communication at the central, district and service delivery levels.

3.5.8 At the central level, the HA head office and SWD headquarters as well as NGOs meet regularly to discuss service strategies and explore models of collaboration. At the district level, the HA's chiefs of psychiatry services and SWD's District Social Welfare Officers liaise regularly with service providers in the district and relevant government agencies to coordinate community support services, and to consider any necessary adjustment to service models having regard to district-specific demographics and service demand. At the service

delivery level, HA's case managers maintain close contact with other service providers, including MSWs and ICCMWs, for discussion and coordination on matters such as case referral and arrangements for rehabilitation services. The three-tier collaboration platform among major service providers is illustrated in Figure 3.5 below.

Figure 3.5: Three-tier collaboration platform amongst major service providers



3.5.9 Feedback from relevant stakeholders and patient groups have identified some service gaps such as unnecessary overlapping of community support between the medical and social sectors, lack of communication platform for service coordination, lack of a common assessment tool for effective patient flow arrangement, and that information exchange is not in a timely and coordinated manner. In order to achieve seamless collaboration between the medical and social sectors and to achieve better community re-integration for SMI patients, community support provided by medical and social sectors should be coordinated and complementary to each other. In this regard, HA, SWD and major NGOs operating community mental health services has set up a task group since 2014 to review the existing service model and develop the “Service Framework on Personalised Care for Adults with Severe Mental Illness in Hong

Kong”⁶⁴ (“the Service Framework”) for enhancing collaboration and communication between the two sectors.

Service Framework on Personalised Care for Adults with Severe Mental Illness in Hong Kong

Objectives

3.5.10 This Service Framework⁶⁵ describes an overarching service model of how community services for adult patients with SMI, their family and carers should be delivered. It seeks to articulate a clear delineation of roles of different service providers, which would help eliminate service gaps and enable service providers to better respond to the needs of patients and families. The document also depicts how an integrated service is formulated based on patients’ individual needs, but not dictated upon professional or organisational boundaries. The specific objectives of the Service Framework are as follows:

- (a) To enhance collaboration and communication between the medical (HA) and social (SWD and ICCMWs) sectors, in the provision of community care for patients with SMI;
- (b) To provide a coordinated community mental health service based on patients’ needs, risks and strength profile; and
- (c) To clearly delineate the roles and responsibilities of various stakeholders facilitating efficient service delivery.

Vision, Mission and Values

3.5.11 Recovery is the common vision of HA, SWD and NGOs when providing services to adults with SMI in the community. The mission of this Service Framework is to facilitate recovery of patients with SMI by providing them and their families with personalised, holistic, timely and coordinated services that meet their medical, psychological and social needs. The core

⁶⁴ Full text of the “Service Framework on Personalised Care for Adults with Severe Mental Illness in Hong Kong” can be downloaded from the following website:
http://www.ha.org.hk/upload/publication_42/513.pdf

⁶⁵ Full text of the Service Framework is available for downloading at the website site below:
https://www.ha.org.hk/upload/publication_42/513.pdf

values of recovery (personal recovery rather than clinical recovery), as a basis of this Service Framework, include hope, autonomy and opportunity.

- (a) Hope - Recovery begins with hope which ignites motivation and sustains effort in the journey of recovery. Despite living with the illness, people can still have a fulfilled and meaningful life.
- (b) Autonomy - Recovery means people taking control over their difficulties, the services they receive, and their lives. Through the process of empowerment as well as helping them to make choices sensibly and responsibly, they define and pursue the meanings of their lives.
- (c) Opportunity - Recovery links with social inclusion and enables people to participate in the wider society.

Essential Components for Effective Delivery of Personalised Care

3.5.12 The effective delivery of personalised care requires a number of essential components providing integrated and coordinated care for adults with SMI:

- (a) A Common Needs-risks-strength Assessment

3.5.13 Personalised care starts with a comprehensive and ongoing assessment on all the needs, risks and strength of the person. A standardised assessment involving structured clinical judgment with a wide array of areas, including current functioning, psychosocial stressors, current clinical conditions, resources, strength and values, and past history of the person, will be used as a common tool among service providers to allow comprehensive care planning and communication among professionals of different disciplines in a structured manner.

(b) Coordination and Collaboration amongst Stakeholders

i) Roles and Responsibilities

3.5.14 An effective provision of community mental health services hinges upon a close partnership between the medical and social sectors and well delineated roles and responsibilities among different stakeholders. The roles and responsibilities of different stakeholders and the core responsibilities of a case manager are clearly defined to facilitate a comprehensive and coordinated support for SMI patients.

ii) Systems for Coordination

3.5.15 Following the implementation of Case Management Programme and ICCMW, a three-tier collaboration platform was instituted by HA and SWD in 2010 to facilitate cross-sectoral communication at the central, district and service delivery levels.

iii) System of Access and Transit

3.5.16 The transit of patients between the medical and social sectors aims at matching the needs and risks of the person with the expertise of the helping professionals and required facilities. In general, a patient with predominant medical needs will have a case manager from the medical sector (community psychiatric services (CPS) of the HA), whereas a patient with more stable mental condition and requiring mainly social rehabilitation services will be under the care of a case manager from the social sector (mainly social workers of ICCMWs or MSWs). The coordination between the CPS and the ICCMW / Medical Social Services Unit (MSSU) in the provision of case management service is illustrated in Figure 3.6 below.

Figure 3.6: Coordination between the CPS and the ICCMW / MSSU in the provision of case management service



iv) Information Sharing

3.5.17 To further enhance the communication amongst stakeholders, timely information sharing between the medical and social sectors will be established on a need-to-know basis. Transfer of personal data is allowed only when it is directly related to the provision of services for individuals. Informed consent for personal data transfer should be obtained upon the first contact with the service provider for sharing of patient’s information in line with the Personal Data (Privacy) Ordinance.

(c) Quality Assurance and Training

3.5.18 To ensure continuous quality improvement, minimise risk and evaluate service delivery, robust governance systems are paramount for both the medical and social sectors. Within HA, the Coordinating Committee (CoC) in Psychiatry is accountable for setting standards and overlooking the quality of CPS. CoC in Psychiatry oversees the implementation of CPS across clusters, including service development, coordination, and monitoring. Each cluster’s CPS unit is accountable for the quality of service, and a Psychiatrist is appointed to lead the CPS team at cluster level.

3.5.19 SWD and NGOs jointly established the Service Performance Monitoring System (SPMS) by stages from 1999 to 2002 to monitor service performance of NGOs. The SPMS ensures accountability on the use of public funds and the provision of quality social welfare services.

3.5.20 Since the establishment of HA Case Management Programme and ICCMW services in 2010-11, a Task Group with representatives from HA, SWD and NGOs were formed to jointly arrange relevant training for relevant stakeholders. Continuous training should be provided to the case managers regarding the evolving disease management, case management, assessment tools, etc.

(d) Sufficient Manpower

3.5.21 To effectively deliver care in a case management model patients with SMI, it is necessary that caseloads and service models in HA and SWD / ICCMWs should be regularly reviewed. In HA, the number of cases handled by each CM varies and the caseload is determined by a number of factors including the complexity of needs of the patients being supported and the experience of individual CMs. Each CM takes care of about 40 to 60 patients with SMI at any one time, maintaining a ratio at about 1:50 on average. In SWD / ICCMWs, each notional team comprises professionals including social workers, psychiatric nurses as well as occupational therapists, and serves a population of around 330 000. It is notable that apart from SMI patients, service users of ICCMWs also include patients with common mental disorders, those with emotional distress and persons suspected to have mental problems. To ensure the provision of quality service, SWD has set up a working group to review, among other things, the caseload of professional staff in ICCMWs. HA and SWD/ICCMWs will continue to review and monitor the service provision and manpower with a view to further strengthening support for SMI patients.

(e) Service User Involvement

3.5.22 Service user involvement, such as recruiting peer support workers or collecting feedback from service users, is important for their contributions in supporting the mental health service as well as informing future service planning. Peer support workers, who are service users doing well in their recovery, can be employed / engaged in a service team and play an important role in helping

patients to identify personal recovery goals and develop illness management skills. Both HA and SWD has launched peer support programmes since 2015-16. Furthermore, regular meetings with various patient groups are held to collect their feedback for continuous quality improvement.

3.5.23 During the development of this Service Framework, a number of priority areas of unmet needs have also been identified, including vocational rehabilitation, physical health of patients with SMI, support provided to caregivers and children of patients with SMI and combating stigma and discrimination on mental illness. These needs will be further addressed by the medical and social sectors in other platforms.

Consultations and Follow-up Work

3.5.24 The draft Service Framework with the aforementioned components was prepared in mid-2015. A series of joint consultation forums and meetings, co-organised by HA and SWD, were conducted for stakeholders, including HA, SWD, NGOs, patient groups, self-help groups, private psychiatrists, the Equal Opportunities Commission, the Hong Kong Council of Social Service and Legislative Councillors.

3.5.25 The Service Framework was published in July 2016. To implement the Service Framework, an implementation task force with the representatives of HA, SWD and major NGOs operating community mental health support services has been set up in the first quarter of 2016 to:

- (a) develop a common needs-risks-strength assessment tool;
- (b) develop an operation guideline;
- (c) develop a mechanism for timely information sharing; and
- (d) arrange staff training.

Patients with CMD

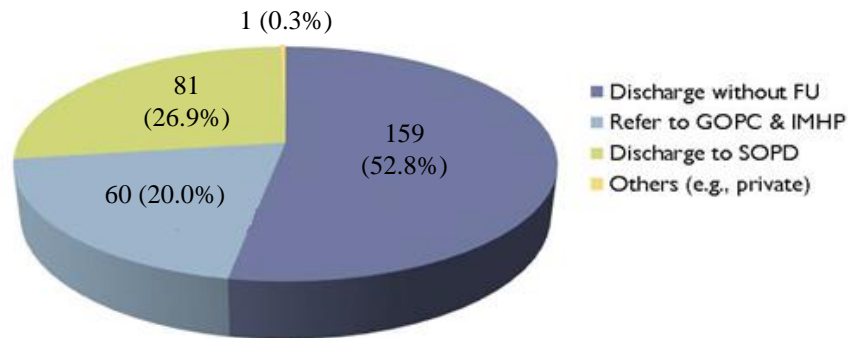
3.5.26 To enable early diagnosis and treatment of patients with CMD such as depression and anxiety disorders, HA has set up dedicated CMD clinics at its psychiatric SOPCs since 2010 for fast-tracking some 7 000 cases annually.

3.5.27 With increasing demand for mental health services and the majority of persons on waiting list at SOPCs being CMD cases (including mild depression, anxiety or insomnia), HA has further enhanced the services for CMD by piloting an enhanced CMD Clinic at Kwai Chung Hospital of the Kowloon West Cluster in July 2015 with a view to shortening the SOPC waiting time. The pilot programme has enhanced the multi-disciplinary element in the service delivery model by engaging more psychiatric nurses, clinical psychologists and allied health professionals to provide more active and personalised psychosocial interventions for targeted CMD patients, such that doctors can devote more time to managing new cases.

3.5.28 Under the pilot programme, suitable patients will be first assessed by a multi-disciplinary team including psychiatric doctor, psychiatric nurse and occupational therapist. Based on the assessment results and a multi-disciplinary case conference, an individual care plan will be formulated. Depending on patient's clinical needs, patients will then receive intensive psychosocial interventions as appropriate. A nurse coordinator will be assigned to each patient to closely monitor patients' progress with a view to enhancing treatment outcomes and facilitating discharge from the psychiatric SOPC upon completion of the CMD programme.

3.5.29 With the implementation of the new service model for patients with CMD, the preliminary result indicates that the 90th percentile waiting time of patients booking new cases at the adult psychiatric SOPCs triaged into routine cases in Kowloon West Cluster decreased from 61 weeks in June 2015 (before the enhancement) to 47 weeks in March 2016. In addition, more than half who completed the treatment programme could be successfully discharged from the psychiatric SOP service.

Figure 3.7 CMD pilot programme - Preliminary findings



3.5.30 Under this pilot programme, a centrally coordinated cross-cluster referral also started in November 2015 to facilitate patients in accessing psychiatric service. As of 31 March 2016, 121 cross-cluster referrals were received. In July 2016, the CMD Clinic was expanded to the Kowloon East Cluster.

Patients with Learning Disability

3.5.31 For patients with severe and profound intellectual disability, infirmary and rehabilitation in-patient services are provided by the Siu Lam Hospital. Apart from medical treatment and nursing care, these patients also receive rehabilitation services including occupational therapy, physiotherapy, prosthetic and orthotic services, medical social services as well as social education training aiming to improve quality of life, maximise patients' self-care abilities, improve physical mobility, and treat associated medical or psychiatric conditions like epilepsy or challenging behaviours.

3.5.32 In the past three years from 2013-14 to 2015-16, there were a total of 83 new applications for the infirmary and rehabilitation services provided by Siu Lam Hospital. In the same period, there were 57 patients with severe and profound intellectual disability admitted to Siu Lam Hospital. The median waiting time for admission in 2015-16 is about 24 months. As at 31 March 2016, there were a total of 19 patients on the active central waiting list.

3.5.33 Recognising the intensive care needs of these patients, HA started the planning and renovation works in Siu Lam Hospital in 2014-15 to make available space for additional 20 beds on top of its existing 500 beds, with a view to clearing up the waiting list by phases in the coming years. The renovations works had been completed and the new ward with additional 20 beds was opened in December 2016. It is expected that the waiting list will start to be cleared up upon the enhancement of manpower, including nursing staff and allied health professionals.

3.6 Service Gaps

3.6.1 The services for adult patients with mental illness have been significantly enhanced over the past years. The enhancement measures have recorded positive outcomes since inception. Nevertheless, the Review Committee considers that there are still rooms for further improvement so that the quality of life of people suffering from mental illness could be further improved and that services required would be made more readily accessible to persons in needs. Most important of all, community support should be further strengthened to help people recovering from mental illness re-integrate into society.

3.6.2 The EASY programme has managed to reduce the time between onset of symptoms and interventions, and hence lowered the possibility of future relapse and treatment resistance. However, due to limited resources, not all new cases with first-episode psychosis are covered under the programme at the moment.

3.6.3 The Case Management Programme has achieved positive outcomes with its personalised support to patients with SMI. Nevertheless, the Review Committee considers that the existing ratio of a case manager to patients with SMI at about 1:50 should be further strengthened taking into account the intensity of the support services required by a patient with SMI. Improving the ratio is desirable to provide better support services and closer monitoring of the conditions of the patients so that relapse or other problems could be detected earlier.

3.6.4 According to the preliminary findings on the CMD pilot programme, it has proved to be effective to discharge people from SOP service and shorten the waiting time for SOP service. Patients with CMD could also receive services earlier. However, only Kowloon West Cluster and Kowloon East Cluster provide enhanced CMD services at the moment. There is a need to strengthen the multi-disciplinary teams in other clusters and expand the services to all clusters.

3.6.5 The Review Committee also considers that simply strengthening the multi-disciplinary teams is not enough to resolve the bottleneck situation of the SOP service of HA. The Review Committee considers that primary care plays an important role in the maintenance of stable CMD patients. In the light of rising demand for care of CMD patients, healthcare professionals in primary care could enhance its role, capacity and expertise in the long run to help manage stabilised CMD cases in the community or downloaded from HA, and hence enabling more effective and efficient use of psychiatric specialist services at HA. Trainings for healthcare professionals in primary care should be enhanced so that they are equipped with necessary skills and knowledge in providing care to patients with CMD. Without sharing out cases to primary care, the demands for SOP service will remain to be very high and as a result continue to impose pressure on the waiting time of the persons in needs for such service.

3.7 Recommendations and Way Forward

3.7.1 With a view to further enhancing the existing mental health services for patients with SMI, CMD or learning disability, the Review Committee makes the following recommendations -

Services for patients with SMI

1. *To further enhance the support for patients with SMI in the community, HA should conduct a review on the ratio of case manager to patients with SMI with a view to improving the ratio from the current 1:50 to around 1:40 in three to five years' time. Further review should be conducted on whether the ratio could be further improved in the long run. HA should also enhance the peer support services by strengthening the manpower of peer support workers and expanding the coverage of the services in all districts by phases. Regular review*

of the caseload for professional staff in ICCMWs is also essential to ensure the provision of quality services.

2. *To further enhance early detection and intervention of early psychosis during the first three critical years of illness, consideration should be taken to extend the EASY programme so that it can cover all new cases of first episode psychosis by phases.*

Services for patients with CMD

3. *Based on the evaluation outcome of the pilot service model of Kwai Chung Hospital for patients with CMD, HA should take steps to enhance the multi-disciplinary teams and strengthen the psychiatric SOP service in other clusters so that the services of the enhanced CMD clinics could be rolled out to all clusters by phases.*
4. *To reduce the waiting time and enable more effective and efficient use of psychiatric specialist service of HA which should focus on handling more complicated cases, HA should explore the feasibility of introducing a public-private partnership (PPP) arrangement for downloading suitable patients with care plans to private medical practitioners for on-going management of stabilised CMD cases. HA should work out the service delivery model of pilot CMD PPP as early as possible with a view to rolling out the CMD PPP by 2018.*
5. *To facilitate the successful implementation of CMD PPP, the role, capacity and expertise of primary healthcare professionals have to be enhanced through training so as to ensure that they are equipped with relevant knowledge and skills to manage patients with stable CMD in the community or cases downloaded/discharged from the psychiatric specialist service of HA.*

Services for patients with learning disability

6. *To clear up the waitlist of patients with learning disability for admission to Siu Lam Hospital, HA should enhance the manpower, including nursing staff and allied health professionals following the opening of the new ward which has provided additional beds in Siu Lam Hospital.*

3.7.2 In reviewing the mental health services for adults, the Review Committee recognises that specialist services of HA is not the only solution for managing people with mental health problems. In fact, concerted efforts of all service providers and stakeholders in the community could help improve the mental well-being and the mental health conditions of people in need. Strengthening the community support for those recovering from SMI (e.g. through enhancing the Case Management Programme and the medical-social collaboration), developing PPP for CMD services, as well as enhancing capacity of primary care should be the direction for service enhancement in future. Providing effective support in the community would help patients with mental illness to integrate into the community as well as to alleviate the burden of the psychiatric specialist services of HA which could then focus on following up more complex cases, allow those recovering from mental illness or suffering from less severe conditions to receive early intervention and support services in the community and minimise the risk of relapse.

Chapter 4 – Dementia Support Services for the Elderly

4.1 Introduction

Dementia – A Public Health Challenge

4.1.1 Dementia is an emerging public health challenge for countries around the world. Improvements in healthcare have contributed to people living longer and healthier lives. However, it has also resulted in an increase in the number of people suffering from non-communicable diseases, including dementia which mainly affects older people. Dementia not only disturbs those who have it as well as their carers and families, but also poses substantial challenge to healthcare and social care systems worldwide.

4.1.2 With an ageing population that is among those who enjoy the highest life expectancy in the world, Hong Kong is not immune to the challenge. Because of the irreversible nature of dementia and the heavy dependency on support services from persons with dementia, the cost of care and the burden of dementia on our medical and social systems will keep rising as our population continues to age and the number of persons with dementia continues to increase. Figure 4.1 introduces what dementia is and its causes are.

Expert Group on Dementia

4.1.3 Recognising this challenge, the Government sees an imminent need to revisit its existing service delivery model and strengthen its response to the challenge. An Expert Group on Dementia was therefore established in December 2013 under the Review Committee on Mental Health chaired by the Secretary for Food and Health to carry out this worthy mission. Comprising a broad representation of stakeholders (membership at **Annex E**), the Expert Group is tasked to articulate a sustainable service delivery model of care for persons with dementia and map out the future direction of dementia care.

Figure 4.1 Dementia – The Disease and Its Causes

What is dementia?

- The International Statistical Classification of Diseases and Related Health Problems 10th Revision defines dementia as a syndrome due to disease of the brain – usually of a chronic or progressive nature – in which there is disturbance of multiple higher cortical functions, including memory, thinking, orientation, comprehension, calculation, learning capacity, language, and judgement. Consciousness is not clouded. The impairments of cognitive function are commonly accompanied, and occasionally preceded, by deterioration in emotional control, social behaviour, or motivation. This syndrome occurs in a large number of conditions primarily or secondarily affecting the brain.

What causes dementia?

- The commonest cause of dementia is Alzheimer's disease, an irreversible degenerative disorder of the brain, followed by vascular dementia. The strongest evidence for possible causal associations with dementia is those of low education in early life, hypertension in midlife, and smoking and diabetes across the life course. There is persuasive evidence that the dementia risk for populations can be modified through reduction in tobacco use, better control and detection for hypertension and diabetes, as well as cardiovascular risk factors.

4.1.4 Since its establishment in December 2013, the Expert Group has examined the burden of dementia on the healthcare and social care systems (Section 4.2), reviewed the existing services provided to persons with dementia and identified gaps that require further work (Section 4.3). The Expert Group has also made recommendations on how the existing model of care should be refined and services enhanced to meet the challenges arising from a growing population with dementia (Sections 4.4, 4.5 and 4.6).

4.1.5 Persons with dementia should live with dignity as valued members of the society. The recommendations in this report reinforce the Expert Group's belief that promoting greater understanding of dementia is the first and foremost step to tackle the challenge because delaying the onset and progression of this irreversible disease would significantly lower the burden of society, especially an ageing one.

4.1.6 At the same time, the refined service delivery model of dementia care will enable the parties concerned to better coordinate their resources and services in a way that matches with the individual needs of persons with dementia. Above all, an effective partnership among different sectors is crucial to ensure the provision of holistic care and quality services to persons with dementia and, for this, the Expert Group appeals to the concerted efforts of the community.

4.2 The Burden of Dementia

The Global Burden of Dementia

4.2.1 Dementia is a syndrome that most commonly affects older people. According to different estimates, between 2% and 10% of all cases of dementia start before the age of 65. The prevalence doubles with every five-year increment in age after 65. The number of people globally who are living with dementia currently is estimated to be 47 million. This number is expected to grow at an alarming rate to more than 75 million in 2030. The number is expected to triple by 2050.⁶⁶

4.2.2 Despite the increasing occurrence of dementia among all populations, the disease is under-diagnosed worldwide. According to the World Alzheimer's Report 2011, only one fifth to one half of dementia cases are diagnosed and documented in high-income countries. WHO estimated that the global societal economic cost of dementia reached US\$604 billion (HK\$4,711 billion) in 2010. By 2030, the cost of caring for people with dementia worldwide could be an estimated US\$1.2 trillion (HK\$9.36 trillion) or more, which could undermine social and economic development throughout the world. In high-income countries, informal care (e.g. unpaid care provided by the family), formal social care and direct medical costs account for 45%, 40% and 15% of costs respectively. In low-income countries where institutional and community services are much less developed, informal care costs predominate. Figure 4.2 lists the principles and approaches identified by WHO in tackling dementia globally.

⁶⁶ First WHO Ministerial Conference on Global Action Against Dementia, 2015.

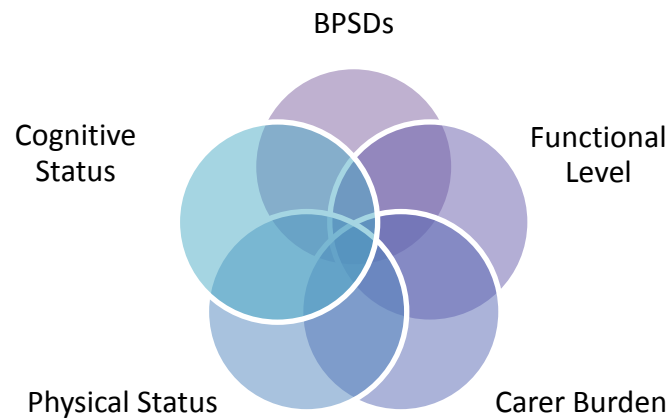
Figure 4.2 Global Action Against Dementia

Recognising dementia as an emerging public health challenge for countries around the world, the WHO reckons that no single country, sector or organisation can tackle this alone. A sustained global effort is required to promote global action against dementia and address the challenge posed by dementia. The First WHO Ministerial Conference on Global Action Against Dementia, held in March 2015, has identified the following overarching principles and approaches as being integral to global efforts:

- Empowering and engaging the full and active participation of persons with dementia, their carers and families to overcome stigma and discrimination;
- Fostering collaboration between all stakeholders to improve prevention and care, and to stimulate research;
- Building on and utilising existing expertise, collaborative arrangements and mechanisms to maximise impact;
- Balancing prevention, risk reduction, care and cure so that whilst efforts are directed towards finding effective treatments and practices, and risk reduction interventions, continuous improvements are made on care for people living with dementia and support for their carers;
- Advocating for an evidence-based approach and shared learning, allowing advances in open research and data sharing to be available to facilitate faster learning and action;
- Emphasising that policies, plans, programmes, interventions and actions are sensitive to the needs, rights and expectations of persons living with dementia and their carers; and
- Embracing the importance of universal health coverage and an equity-based approach in all aspects of dementia efforts, and to facilitate equitable access to health and social care for people living with dementia and their carers.

4.2.3 Dementia is challenging because the clinical course and care needs vary from one person to another. According to WHO⁶⁷, the problems linked to dementia can be understood in three stages. As the disease progresses, persons with dementia tend to manifest mental, behavioural, physical and social problems and require a variety of support at different levels of intensity along the care pathway. Figure 4.3 shows the five different domains of dementia⁶⁸ and figure 4.4 shows the common symptoms experienced by persons with dementia.

Figure 4.3 Five Domains of Dementia



⁶⁷ World Alzheimer's Report 2009. London, Alzheimer's Disease International, 2009.

⁶⁸ Behavioural and Psychological Symptoms of Dementia (BPSD) include symptoms like depression, anxiety, agitation, aggression, hallucinations, delusions, apathy, etc. They occur in most people with dementia and are associated with poor quality of life of patients, carers' stress, premature hospitalisation and excess morbidity and mortality. Management of BPSDs is difficult and challenging.

Figure 4.4 Common Symptoms Experienced by Persons with dementia

Early stage 1st & 2nd Year	Middle stage 2nd to 4th or 5th Year	Late stage 5th Year and After
<p>The early stage is often overlooked. Relatives and friends (sometimes professionals as well) see it as “old age”, just a normal part of ageing process. Because the onset of the disease is gradual, it is difficult to be sure exactly when it begins.</p> <ul style="list-style-type: none"> • Become forgetful, especially regarding things that just happened • May have some difficulty with communication, such as difficulty in finding words • Become lost in familiar places • Lose track of the time, including time of day, month, year, season • Have difficulty making decisions and handling personal finances • Have difficulty carrying out complex household tasks • Mood and behaviour: <ul style="list-style-type: none"> - may become less active and motivated and lose interest in activities and hobbies - may show mood changes, including depression or anxiety - may react unusually angrily or aggressively on occasion 	<p>As the disease progresses, limitations become clearer and more restricting.</p> <ul style="list-style-type: none"> • Become very forgetful, especially of recent events and people’s names • Have difficulty comprehending time, date, place and events; may become lost at home as well as in the community • Have increasing difficulty with communication (speech and comprehension) • Need help with personal care (i.e. toileting, washing, dressing) • Unable to successfully prepare food, cook, clean or shop • Unable to live alone safely without considerable support • Behaviour changes may include wandering, repeated questioning, calling out, clinging, disturbed sleeping, hallucinations (seeing or hearing things which are not there) • May display inappropriate behaviour in the home or in the community (e.g. disinhibition, aggression) 	<p>The last stage is one of nearly total dependence and inactivity. Memory disturbances are very serious and the physical side of the disease becomes more obvious.</p> <ul style="list-style-type: none"> • Usually unaware of time and place • Have difficulty understanding what is happening around them • Unable to recognize relatives, friends and familiar objects • Unable to eat without assistance, may have difficulty in swallowing • Increasing need for assisted self-care (bathing and toileting) • May have bladder and bowel incontinence • Change in mobility, may be unable to walk or be confined to a wheelchair or bed • Behaviour changes, may escalate and include aggression towards carer, nonverbal agitation (kicking, hitting, screaming or moaning) • Unable to find his or her way around in the home

Source: Dementia – A Public Health Priority. Geneva, WHO, 2012.

4.2.4 When the conditions of persons with dementia worsen, the burden on their carers (including the patients’ family members) would also increase significantly. Figure 4.5 lists out the needs of carers of dementia patients.

Figure 4.5 The Needs of Carers

Informal care is the cornerstone of care for people who have lost the capacity for independent living. It is important that the needs of carers are taken into account so as to enable persons with dementia and their carers to cope with the disease together. In fact, carers should be included as partners in the provision of care. Carers' observations of the changing cognitive state and their familiarity with the person with dementia will often be invaluable to the clinical team. The needs of carers are summarised as follows –

Need for information on dementia and community resources

- Such information will empower carers to take care of their elderly dependants with the help of community support resources. Availability of such information is crucial to help them get acquainted to the caring role and perform the caring tasks more competently.

Physical care assistance

- Taking care of someone with impairments involves considerable amount of physical labour. Carers may need assistance in lifting the demented in and out of the bath, etc. Carers who are weak in physical strength often report injuries and such physical stresses may also exacerbate their existing chronic illness, such as arthritis and hypertension.

Training on skills of taking care of persons with dementia

- To deal with the cognitive and physical impairments of the demented, training for carers on methods to deal with the problems of memory loss, disorientation, bedding, dressing, etc. are thus essential.

Respite services

- It is widely recognised that both day and residential respite care can relieve the burden in giving care and allow the family to continue in the role of care.

Emotional support

- Since the caring role brings about various kinds of stress, counselling and emotional support for carers play a crucial role to help them through difficult times.

Recognition

- Carers deserve wider recognition. They have invaluable insights of the patients' conditions and should be involved in the formulation of care plans for persons with dementia.

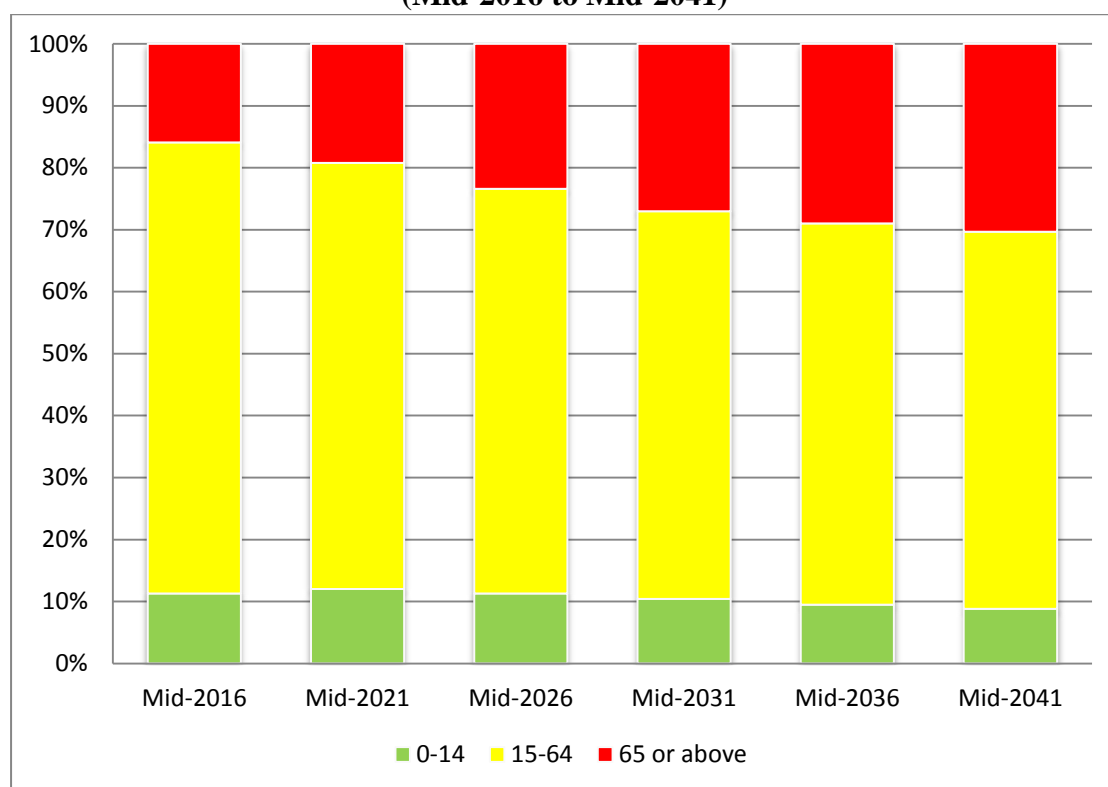
Financial assistance

- Caring for patients with dementia can be a full-time responsibility. As the conditions of the frail elderly deteriorate, carers need adaptations to their living environment or purchase special equipment. Carers from low income families may need financial assistance while it is equally important to preserve the family support spirit.

A Snapshot of Our Current Situation

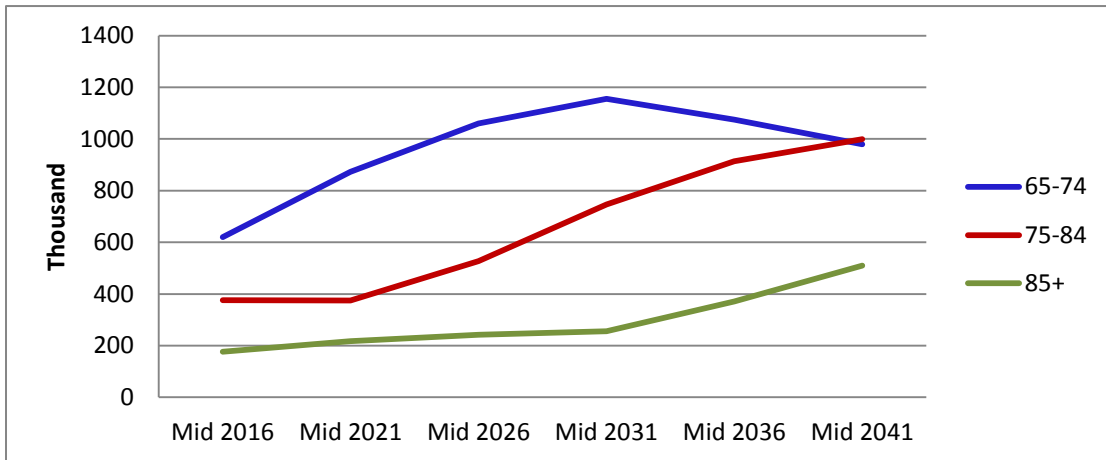
4.2.5 As the case in comparable economies across the world, our ageing population is having a profound impact on the emergence of dementia. In Hong Kong, people aged 65 or above currently make up about 16%, or about 1.2 million, of our population. By 2041, it is projected that almost one in three of our population will be aged 65 or above (Figure 4.6). Figure 4.7 further shows the ageing trend of the older age groups. Starting from 2031, the number of people aged 85 or above will rise rapidly and this will have significant impact on elderly care as dementia tends to be more prevalent in older age groups. Understanding the burden of dementia on our medical and social care systems will help us identify priority areas for action and focus efforts in planning services for persons with dementia.

Figure 4.6 Percentage of Hong Kong's Population by Age
(Mid-2016 to Mid-2041)



Source: Hong Kong Census and Statistics Department

**Figure 4.7 Growing Trend of Hong Kong's Aged Population
(Mid-2016 to Mid-2041)**



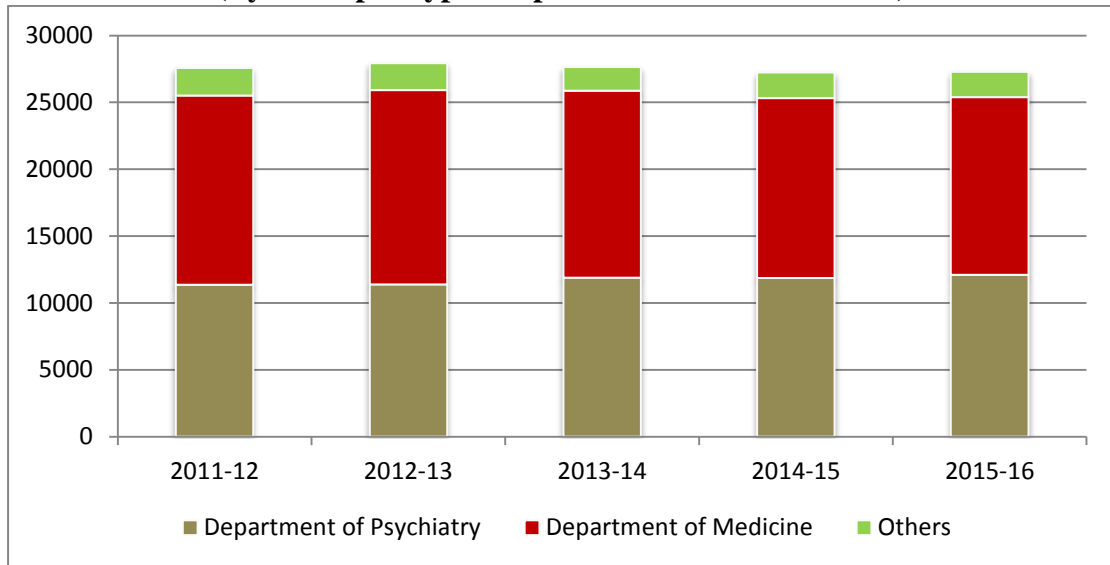
Source: Hong Kong Census and Statistics Department

4.2.6 Over the past years, there have been various studies conducted by academics and service providers attempting to scope the problem of dementia in Hong Kong, with the gloomiest estimates putting our demented population at 100 000.⁶⁹ While there is no regular survey of the demented population diagnosed by the private sector, that recorded by the public healthcare system is on the clear rise.

4.2.7 About 28 000 people living with dementia are receiving specialist services in HA. This is compared to about 19 000 patients in 2008-09. The majority of them are aged over 70. Depending on their principal diagnosis and the symptoms they manifest, persons with dementia are mainly followed up by the Department of Psychiatry or the Department of Medicine at HA. The number of persons with dementia receiving care at HA with breakdown by the type of specialist services provided and by age are illustrated in Figures 4.8 and 4.9.

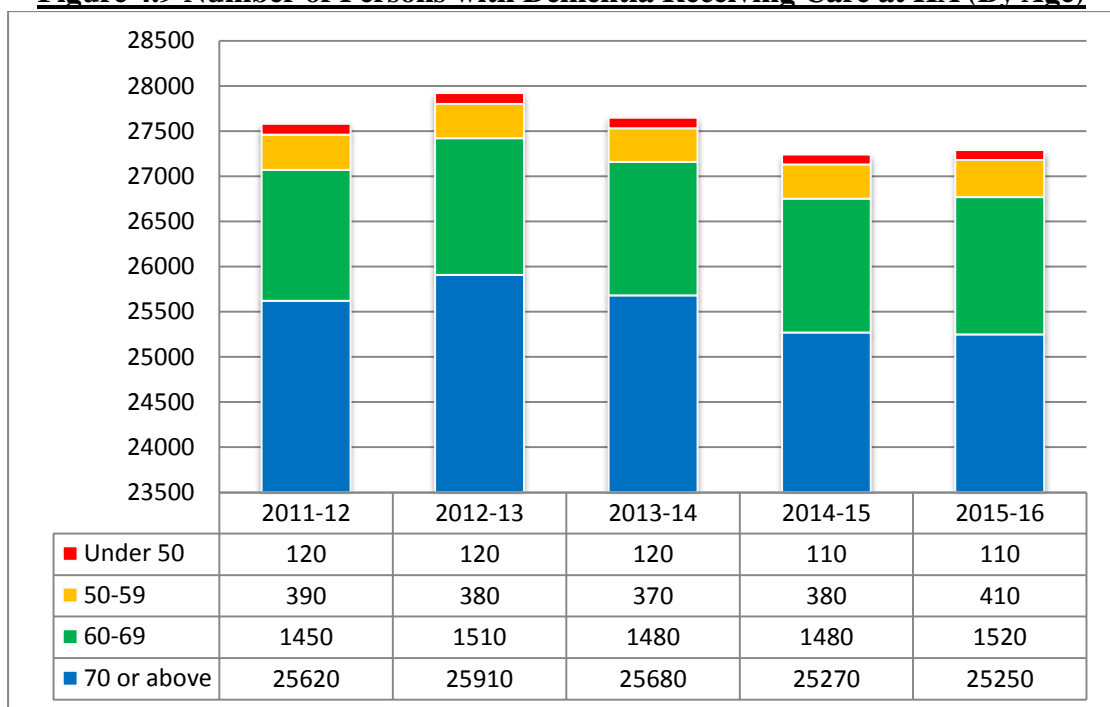
⁶⁹ In Hong Kong, some population-based research (e.g. Challenges of Population Ageing on Disease Trends and Burden conducted by CUHK and the University of Hong Kong in 2010 and Trends in Prevalence and Mortality of Dementia in Elderly Hong Kong Population: Projections, Disease Burden, and Implications for Long-Term Care conducted by the CUHK in 2012) put estimates of our demented population at around 100 000.

**Figure 4.8 Number of Persons with Dementia Receiving Care at HA
(By Principal Type of Specialist Services Provided)**



Source: HA

Figure 4.9 Number of Persons with Dementia Receiving Care at HA (By Age)

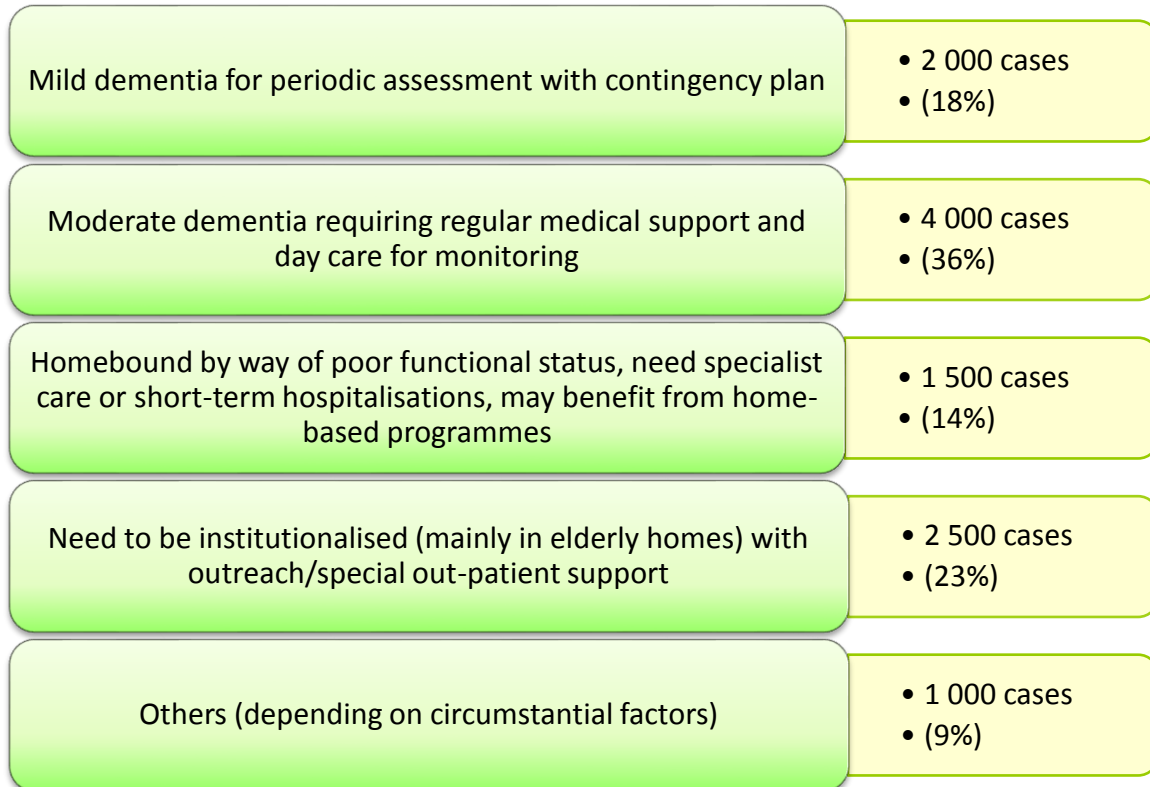


Source: HA

4.2.8 An analysis on the severity of persons with dementia being followed up by the Department of Psychiatry of the HA would shed some light on the care needs of persons with dementia (Figure 4.10). Among the 11 000 plus cases of dementia, slightly more than half of them are persons with mild or moderate dementia. People at this stage are in transition between healthy, active life and frailty. With appropriate support, these people are able to manage their health conditions. This is precisely the time when intervention, especially at the primary care level, should be given to prolong the progression of their disease so that patients can stay in the community for as long as possible. It will also reduce unnecessary and premature admission to infirmaries, hospitals and residential care homes for the elderly (RCHEs), and in turn improve their quality of life before reaching the severe stage of dementia.

4.2.9 About 14% of persons with dementia are at moderate and moderate to severe stages where they are homebound because of various levels of physical impairments. About 23% of persons with dementia need to be institutionalised because the disease has advanced to a stage where they cannot live safely and independently in the community. These persons require more intensive medical and social support.

**Figure 4.10 Analysis of the Level of Severity
of Patients at the Department of Psychiatry of HA**



Source: HA.

The breakdown is based on a survey of patients being followed up by the Department of Psychiatry. It is found that the level of severity of persons with dementia being followed up by the Department of Medicine follows a similar pattern.

Scope for Further Study

4.2.10 Monitoring the prevalence of dementia and estimating the cost of care is a complicated and ongoing exercise. While increased awareness will boost demand for care, changes in risk exposure (e.g. healthier lifestyles, more positive help-seeking behaviour, etc.) may delay onset or alter the rate of incidence. We will need up-to-date, territory-wide epidemiological studies to gauge the prevalence of dementia and make reliable estimates for the purpose of service planning. As different types of dementia (e.g. Alzheimer's disease, Vascular dementia, Dementia with Lewy bodies) require different prevention strategies and treatments, it is also important to monitor the prevalence of their types so that resources can be directed in a more targeted way when formulating care plans and programmes. There is also a need to assess regularly the effectiveness of prevention programmes and strategies on dementia care. Despite the fact that our society is ageing, if the onset and progression of

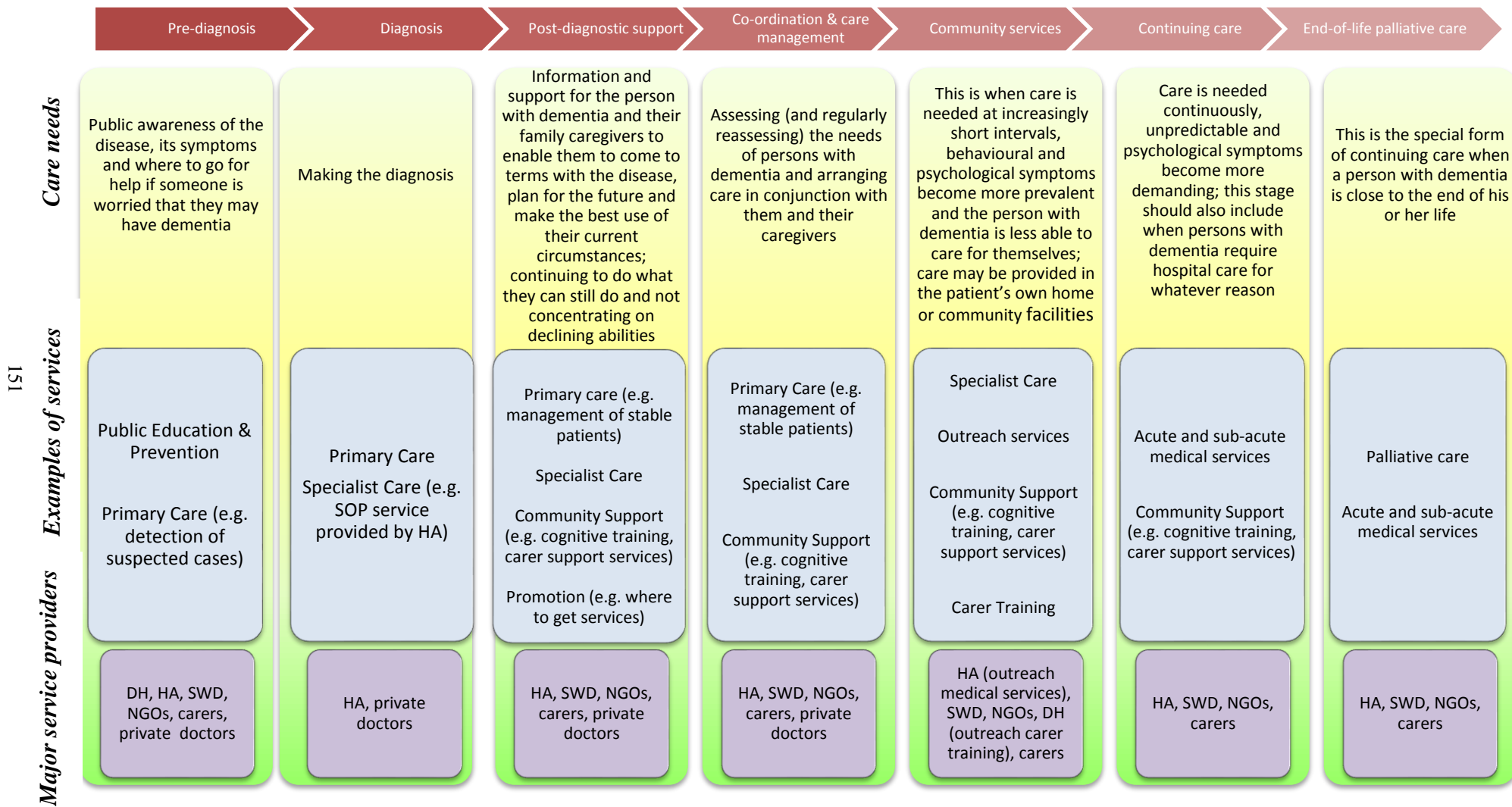
dementia could be delayed because of better awareness and enhanced care, it would have significant implications on the number of people affected and the services that would be required. This will have a major impact not only on individuals and families but also on service provision and on society as a whole. Further epidemiological studies may therefore help inform our future efforts to tackle the challenge of dementia.

4.3 Existing Services for Persons with Dementia

A Seven-stage Model for Planning Dementia Services

4.3.1 The care pathway for dementia is often characterised by the diverse needs of patients at various stages. Governments across the globe have tried to put in place an integrated system of care services that would address the multiple needs of persons with dementia and their carers. To help governments plan for dementia services, the WHO and the Alzheimer's Disease International have promulgated a seven-stage model seeking to address the needs of persons with dementia beyond the pre-diagnostic and diagnostic phases. The seven stages cover pre-diagnosis, diagnosis, post-diagnostic support, coordination and care management, community services, continuing care and end-of-life palliative care. The model recognises the importance of ongoing care in the community for people diagnosed with dementia and puts particular emphasis on a range of post-diagnostic support and long-term care services that aim to enable persons with dementia to stay in the community. As illustrated in Figure 4.11, dementia care services are organised along the aforementioned seven-stage model, which emphasizes the need for a continuum of health and social services to be provided to persons with dementia and their carers throughout the journey of dementia care.

Figure 4.11 Seven-Stage Model for Planning Dementia Services Promulgated by WHO and the Alzheimer’s Disease International



4.3.2 In Hong Kong, having regard to the changing care needs of dementia, the Government adopts a multi-disciplinary and cross-sectoral approach in the provision of holistic care to people living with dementia. From prevention and early detection to timely treatment and provision of long-term care, FHB, LWB, HA, DH, SWD and other relevant parties including NGOs all work together to address the complex needs of persons with dementia. The existing services for persons with dementia are summarised in the ensuing paragraphs. Figure 4.12 shows the three different levels of prevention of dementia.

Figure 4.12 Prevention of Dementia

Prevention of dementia can be understood in three conventional levels – primary, secondary and tertiary. It is important to understand what they are so that prevention strategies can be targeted and results effective.

Primary prevention –

Primary prevention consists of measures taken for disease prevention via risk reduction. From promoting healthy lifestyles to social engagement after retirement, the prevention strategies cover almost all walks of life and aim to increase the brain and cognitive reserve of population, and hence delay the onset of dementia.

Secondary prevention –

Secondary prevention includes the detection and diagnosis of the disease, enabling the instigation of interventions to manage the disease’s progression and development of complications, and facilitating the planning of supportive services. It also includes the delaying of the onset of functional and cognitive decline via pharmacological and non pharmacological means.

Tertiary prevention –

Tertiary prevention aims at reducing the impact of complications of dementia, improving the quality of life and maximising potential years of useful life. It includes accurate assessment of the patient’s needs, individualised care and support for the family carers.

Existing Services along the Continuum of Care

Public Education and Prevention

4.3.3 Noting that controlling modifiable risk factors (e.g. smoking, obesity, physical inactivity) and early help-seeking behaviour may help delay the onset of dementia and its deterioration, DH has produced health education materials (such as pamphlets, books and videos) and used various media (such as media interviews and webpage) to raise community awareness, promote dementia care and remove stigma surrounding dementia in addition to promoting healthy lifestyles to build up cognitive reserve. Training has also been provided to frontline staff of public utilities and services who are likely to come across clients with dementia to offer early assistance during their day-to-day operation. From time to time DH, HA, SWD and NGOs also organise programmes and seminars to educate the public about the disease, its symptoms and where to seek help if someone is suspected to have developed dementia.

Primary Care

4.3.4 As a first point of contact, HA's general out-patient clinics, EHCs under DH and medical practitioners in private practice play an important role in detecting early symptoms of dementia, as well as diagnosing it in the community. They also help refer persons with dementia or suspected cases to specialist care in HA or the private sector for further investigation, treatment and provide follow-up consultations for stabilised cases. Figure 4.13 below lays out the role of primary care in dementia care.

Figure 4.13 The Role of Primary Care in Dementia Care

Primary care plays an important role in detecting and diagnosing early symptoms of dementia. Private GPs, family doctors and doctors at public GOPCs are usually the first point of contact for a person with a medical issue requiring attention. Primary care doctors with the necessary training and experience can make diagnosis and prepare persons with dementia for the way forward. Early diagnosis and effective communication will allow persons with dementia and their family members to make preparations and understand treatment options. Primary care doctors can also help enhance their literacy on dementia so that they will be better equipped with the knowledge to cope with the disease.

Another important role of primary care doctors is maintenance and management of disease. Primary care doctors also act as a gateway to services including community-based and specialist services. According to the complexity of the disease, primary care doctors can refer them to services that address the impact of dementia and related conditions. The family doctors must therefore be familiar with supportive facilities in the district.

A strong primary care foundation and network will allow stable cases of dementia to be managed in the community. Through education and promotion, persons with dementia should be encouraged to return to primary care. Effective stratification will allow specialists more time to handle complex cases of dementia.

Specialist Care

4.3.5 About 28 000 patients with varying degree of dementia are being followed up by HA. The multi-disciplinary teams of HA comprising healthcare practitioners in various disciplines provide comprehensive and continuous medical services to patients with dementia. The Department of Medicine and the Department of Psychiatry of HA hospitals jointly provide multi-pronged assessment and therapy to patients with dementia. Depending on the severity of the condition, patients may be referred to relevant specialist for follow-up treatment by geriatricians and psycho-geriatricians as appropriate. The multi-disciplinary teams will formulate individualised treatment plans with a view to providing comprehensive and continuous medical services. Based on individual's needs, appropriate medication, cognitive training, assessment of activity of daily living and rehabilitation services will be provided on a case-by-case basis. In recent years, HA has increased the use of new anti-dementia drugs

with proven clinical efficacy to improve the quality of life and delay the functional deterioration of patients with dementia.

Subsidised Support and Care Services for Persons with Dementia

4.3.6 The Government has been providing a wide range of subsidised support and care services to elderly persons, including those with dementia.

Subsidised Community Support Services

4.3.7 The Government provides community support services for elderly persons (including those suffering from dementia) and their carers at district and neighbourhood levels through the 210 subvented elderly centres⁷⁰ under SWD. The services include training and counselling services, assistance in forming carers' mutual help groups, setting up resources centres and demonstration and loan of rehabilitation equipment, etc. In addition, since 2014-15, an additional full-year recurrent funding of some \$22 million has also been provided to all 41 subvented DECCs in the territory to employ more social workers with a view to enhancing the support services for elderly persons with dementia and their carers.

Subsidised Community Care Services

4.3.8 The Standardised Care Need Assessment Mechanism of Elderly Services (SCNAMES) adopts an internationally recognised assessment tool to assess the elderly persons' abilities in looking after themselves, their physical functioning, memory, communication skills, behaviour and emotion, health conditions, living environment and abilities in coping with their daily activities, etc. A wide spectrum of subsidised community care services and residential care services to the elderly persons with proven long-term care needs (including those suffering from dementia) as assessed by SCNAMES are being provided by the Government to promote their well-being. However, there are views within frontline service providers that the existing assessment tool may not be sensitive in identifying the cognitive and mental needs of persons with dementia in the early stages. To address such concern among others, SWD has tasked the

⁷⁰ At present, there are 210 elderly centres, including 41 DECCs and 169 Neighbourhood Elderly Centres under Government subvention in the territory. As at end-September 2016, these elderly centres had about 210 000 registered members.

Sau Po Centre on Ageing, the University of Hong Kong to upgrade the existing SCNAMES from interRAI-Home Care 2.0 to interRAI-Home Care 9.3. Upon completion of necessary training programmes, the new SCNAMES will be rolled out for use in the second quarter of 2018.

4.3.9 The Government provides community care services to frail elderly persons, including those with dementia, living in the community and their families through 73 day care centres/units (DEs/DCUs) for the elderly, 34 Enhanced Home and Community Care Services teams, and 60 Integrated Home Care Services teams.

4.3.10 At present, elderly persons with dementia are served in an integrated manner in one day care facility (i.e. DEs/DCUs) in order to ensure that they can receive appropriate care services at different stages. Cognitive training, memory training, reality orientation and reminiscence therapy, etc., are provided at all DEs/DCUs for elderly persons with dementia. As at end December 2016, there were 73 DEs/DCUs with 3 059 subsidised day care places, serving some 4 430 elderly users assessed by SCNAMES as having moderate or severe level of impairment, including those who suffer from dementia. No quota has been set aside for dementia-specific purpose.

4.3.11 Some elderly persons are provided with home care services rather than centre-based services at DEs/DCUs. Under the Integrated Home Care Services (Frail Cases) and the Enhanced Home and Community Care Services, a range of care services similar to those provided by DEs/DCUs are offered to frail elderly persons in accordance with their individual care plans. For elderly service users who are suffering from dementia, cognitive training will also be provided. As at end December 2016, there were 8 365 service places.

4.3.12 In September 2013, SWD launched the First Phase of the Pilot Scheme on Community Care Service Voucher for the Elderly, with a total of 1 200 vouchers issued. The Pilot Scheme adopts the “money-following-the-user” approach, allowing eligible elderly persons to flexibly choose the subsidised service packages and the service providers that best suit their individual needs. It also encourages service providers to design different service packages to meet the care needs of individual voucher users. The Second Phase of the Pilot Scheme was launched on 3 October 2016 with a total of 3 000 vouchers, including the 1 200 vouchers under the First Phase for migration to the Second

Phase. Among the 124 recognised service providers participating in the Second Phase of the Pilot Scheme, 18 have drawn up specific service packages for elderly persons with dementia, providing a total of 560 service places in all 18 districts across the territory.

Subsidised Residential Care Services

4.3.13 Owing to their increasing frailty and/or other reasons (e.g. family circumstances, etc.), some elderly persons have to resort to residential care services by moving into RCHEs (instead of living at their homes). As at end-December 2016, there were a total of some 74 300 residential care places, of which about 27 400 were government subsidised places provided by 127 subvented RCHEs, 28 contract RCHEs and 148 private/self-financing RCHEs participating in Enhanced Bought Place Scheme (EBPS) and Nursing Home Place Purchase Scheme. The remaining some 46 900 places are non-subsidised places provided by the above-mentioned operators in different types of RCHEs (the majority of those places are provided by private RCHEs).

4.3.14 The Government has been promoting a continuum of care (COC) in subvented RCHEs, subvented nursing homes and contract homes. SWD launched a programme in June 2005 to convert, in phases, residential care places in 75 subvented self-care hostels and homes for the aged which did not have long-term care element to care-and-attention places providing COC. All places in subvented care-and-attention homes as well as all the 1 574 places at the six subvented nursing homes have been upgraded to places with COC. In 2015-16 and 2016-17, additional resources have also been allocated to 10 new/existing contract RCHEs to provide COC and end-of-life services for the elderly residents therein. Such COC provision is particularly beneficial to elderly persons who may suffer from dementia after they have moved into a particular RCHE.

Provision of Dementia Supplement

4.3.15 Dementia Supplement (DS) has been provided to all subvented RCHEs, private homes participating in EBPS and subsidised DEs/DCUs for the provision of more appropriate services to elderly persons with dementia. The relevant service units may deploy DS to employ additional professional staff, including occupational therapists, nurses and social workers, etc. or purchase relevant professional services to enhance training programmes and services for persons with dementia as well as support services for their carers as necessary. In 2016-17, a total of \$247.6 million of DS has been allocated to 262 eligible RCHEs and 74 DEs/DCUs for about 6 400 beneficiaries. It has been reported that around half of residential clients in subvented and private homes are suffering from dementia in different stages.

Medical Outreach Services Provided by HA

4.3.16 Elderly persons residing in RCHEs with varying degree of dementia are supported by the medical outreach services of HA. The psychogeriatric outreach teams and the community geriatric assessment teams of HA provide a full range of services including formulation of treatment plans, monitoring of patients' progress and follow-up consultations. At present, the community geriatric assessment teams cover about 640 subsidised and private RCHEs while the psychogeriatric outreach services cover most of the subvented RCHEs and contract homes, and over 200 private ones in Hong Kong.

Improving Dementia Care Facilities at Elderly Care Service Units

4.3.17 SWD has enhanced the spatial standard for DEs since October 2010, including the setting up of multi-sensory area for providing training to elderly persons with dementia and increasing the size of physiotherapy room and dining/activity area in the planning of new and reprovisioned DEs. For the existing DEs which do not meet the prescribed spatial standard, SWD will assist service providers acquiring new/additional premises to meet the enhanced spatial standards and will fund the capital works.

Support for Carers

4.3.18 The Government has implemented various measures to support carers of elderly persons. For example, day respite service is provided at DEs/DCUs. On top of designated residential care respite places, SWD also makes use of the casual vacancies of subsidised places in all subvented nursing homes and care-and-attention homes, contract homes as well as private RCHEs participating in EBPS to provide residential respite services. SWD, DH, HA and NGOs also organise training courses, seminars and workshops to educate family carers on how to take care of persons with dementia. In addition, HA provides support and training to family members and carers of persons with dementia through various channels with a view to enhancing their understanding of the disease and improving their skills of care to tackle the behavioural and psychological problems of patients with dementia in a community setting.

4.3.19 In June 2014, the Government launched a two-year Pilot Scheme on Living Allowance for Carers of Elderly Persons from Low-income Families. This pilot scheme aims at providing 2 000 eligible carers from low income families with a living allowance to help supplement their living expenses. These carers are taking care of frail elderly persons living at home including those who suffer from dementia. Phase II of the pilot scheme has been launched since October 2016 for two years. A total of 4 000 carers will benefit from both phases of the pilot scheme. SWD will evaluate the effectiveness, long-term implications to the care-giving policies and the family support structure, etc. of the two phases of the pilot scheme alongside the result of the Pilot Scheme on Living Allowance for Low-income Carers of Persons with Disabilities, and will consider the way forward in the light of the review findings.

4.3.20 HA has also made available information relating to dementia and care management and community resources to support carers of persons with dementia in the community on its “Smart Patient Website”. A new section on “Smart Elders” in the “Smart Patient Website” has been launched to enhance information support for elderly patients (including those suffering from dementia) and their carers.

Training of the Elderly Care Workforce

4.3.21 The Government seeks to strengthen the elderly care workforce by providing regular training. SWD organises regular training programmes for professional (including allied health professionals and social work staff) and non-professional staff (including care workers and health workers) of elderly service units to increase their dementia literacy and enhance their skills in managing the emotional and behavioural problems of elderly persons with dementia. DH deploys its 18 Visiting Health Teams under the Elderly Health Service to deliver on-site training to staff of RCHEs and DE/DCUs so that they are better equipped with the knowledge and skills to care for elderly residents with dementia. HA's psychogeriatric outreach teams and community geriatric assessment teams also provide relevant on-site training to staff of RCHEs to equip them with the necessary skills to provide better caring services to patients with dementia.

Legal Protection

4.3.22 A dedicated legislation - Mental Health Ordinance (MHO) (Cap 136) - is in place to guarantee and protect the rights of people with mental illness, including those who have dementia, throughout the course of illness and recovery. As the disease progresses, persons with dementia may one day become mentally incapacitated and are unable to make decisions. Under Cap 136, a guardian or a committee may be appointed for the purpose of helping to take care of the welfare and financial affairs of the mentally incapacitated person.

4.3.23 Persons with dementia and their family members may also wish to plan ahead and appoint a person or persons who will look after their affairs when they become incapable of doing so. The Enduring Powers of Attorney Ordinance (Cap 501) allows one, while he/she is still mentally capable, to appoint an attorney to take care of his/her financial matters in the event that he/she becomes mentally incapacitated one day.

Service Gaps Identified

4.3.24 The Government endeavours to provide a comprehensive range of services to support persons with dementia as they move through each progressive stage of the disease. Yet the existing services are not free of gaps due to the complexity of the problem which straddles multiple disciplines and sectors. As Hong Kong's population grows and ages, there is a need to revisit the current service delivery model of dementia care. In anticipation of rising demand, there is a need to adopt a more integrated approach in the provision of holistic and coordinated care and ensure that the delivery of services will be sustainable for an ageing population noted for its longevity. The service gaps identified will be discussed in the ensuing paragraphs and Figure 4.14.

Awareness and Understanding of Dementia

4.3.25 As discussed in Chapter 2, the cost and burden of dementia can be substantially reduced if the onset of dementia could be delayed and deterioration postponed. Yet at present this is something impeded by adverse help-seeking behaviour among the general public and knowledge gap in early detection of the disease. Raising awareness and promoting greater understanding of dementia is the first step to reduce stigma and fear associated with dementia.

Bigger Role at Primary Care Level

4.3.26 Much has been discussed about the importance of primary care in the detection and management of dementia (see Figures 4.11 and 4.12). However, the current situation seems to be that there is inadequate expertise and capacity in the primary care setting to facilitate early diagnosis of dementia. The limited capacity is also seen in non-medical sectors where other social care professionals lack the necessary knowledge and skills in detecting suspected cases of dementia, referring them to seek help and understanding the behaviour and needs of those who have the disease. This may be due to the fact that diagnosis of dementia is not always a straightforward task and may involve continuous assessments and monitoring.

4.3.27 However, with suitable training, healthcare professionals in primary care can play a bigger role in diagnosing dementia in its early stage and providing medical treatment and intervention to patients with mild or moderate dementia. Proper gate-keeping in the primary care setting would enable more effective and efficient use of specialist services at HA's hospitals. Transferring stabilised cases of dementia to the community setting for ongoing management while enhancing capacity in secondary care would help shorten the waiting time of specialist services. In view of the ageing trend and the substantial impact of dementia on society, primary care would need to enhance its role and capacity, and for social care, on its knowledge in detecting suspected cases of dementia, if the provision of dementia care is to be sustained.

4.3.28 In this regard, the Expert Group had the opportunity to meet with representatives from the Hong Kong Medical Association (HKMA) to share HKMA's insight in enhancing the role of primary care physicians in dementia care. The HKMA has set up a Taskforce on Dementia Awareness and Management in the Community to study strategies in enhancing the role of primary care physicians in dementia care. Through its nine networks in the territory, the HKMA would, as a start, collaborate with carers and NGOs to promote relevant health education. Efforts will be made to build up more communication platforms among HA, DH, SWD and HKMA to increase the effectiveness in utilising existing resources to provide dementia care.

Post-diagnostic Medical and Community Support Services

4.3.29 Very often, persons with dementia would prefer to remain in the community for as long as possible. This will only be possible if there is adequate access to post-diagnostic support and social care services in the community. The major criticisms surrounding post-diagnostic medical and community support services (e.g. day care, respite services, home-based support, outreach services, primary care, GPs, etc.) include the long waiting time for such services and the lack of proper coordination and communication among service providers in providing stepped-down care. Others also criticise that the current assessment mechanism for determining eligibility of social services is not dementia-sensitive and the services available are not dementia-specific.

4.3.30 As persons with dementia tend to have multiple needs, they will benefit from seamless coordination among service providers and enhanced provision of dementia care in the community. From restorative therapies to end-of-life palliative care, enhanced medical-social collaboration for persons with dementia would spare patients and their carers the trouble of having to navigate among service providers for the support they need. Enhanced medical-social collaboration would also increase efficiency by preventing overlapping of services and resources. This would also reduce unnecessary hospital admissions and patients with severe dementia may not have to undergo invasive intervention that is not conducive to maintaining their quality of life. Appropriate medications in the management of patients with dementia need to be made available and affordable in clinics of primary care, to make early diagnosis and treatment, and subsequent interflow of patients in the integrated clinical programme workable.

4.3.31 Younger Onset Dementia is defined as onset of dementia before the age of 65 years, which also requires enhanced care. These patients usually show cognitive and behavioural symptoms at their late fifties when many are still working for a living. Diagnosis at this stage is often delayed due to denial of the symptoms, inadequate recognition of the symptoms by clinicians in the early stage of the illness, and lower accessibility to secondary or tertiary medical support in some complex cases. The burden caused to the patient and their family is not necessarily lesser than the elder patient group, and supportive programmes for them in the social sector might be further enhanced.

Figure 4.14 Service Gaps Along the Dementia Care Pathway

Although the Government seeks to provide a continuum of services for persons with dementia, the existing services are not without gaps. The Expert Group has identified areas requiring further actions and looked at ways to narrow those gaps.

Service Gaps	Bridging the Gaps
<p>1. Pre-diagnosis - There is limited literature and territory-wide epidemiological studies on local prevalence of dementia for us to fully grasp the current situation. Stigma and fear associated with dementia and a lack of understanding and knowledge of the disease have contributed to adverse help-seeking behaviour. Support (in terms of resources and expertise) for early detection of the disease, as well as for elders and carers before formal diagnosis, needs enhancement.</p> <p>2. Diagnosis - Diagnosis of dementia may involve several tests and scans. Family doctors at private clinics may not have the relevant expertise and multi-disciplinary support to confirm the diagnosis. Elders may need to undergo several (sometimes repeated) tests from different service providers before a formal diagnosis is made. Elders are not familiar with services provided by NGOs or other service providers in private sector. They rely on HA's services, resulting in lengthening the waiting time for a formal diagnosis by HA hospitals.</p>	<p>➤ Pre-diagnosis - Territory-wide epidemiological studies should be conducted regularly to provide information on local prevalence of dementia and facilitate service planning. There is a need to map out prevention strategies through public education and promotion efforts (e.g. how to promote greater understanding and awareness of dementia, reduce exposure to risk factors, reduce stigma, promote conducive help-seeking behaviour, etc.). There is also a need to provide structured training to equip primary care and social care personnel with necessary knowledge to detect symptoms of dementia.</p> <p>➤ Diagnosis - There is a need to enhance the role and capacity of primary care professionals in diagnosing suspected cases and managing stabilized cases of dementia so that more complex cases can be referred to specialists for treatment. A common reference can be developed to support primary care professionals on the diagnosis and management of dementia. Capacity in secondary care should be enhanced. There is a need to optimise the use of resources in the primary care sector with a view to reducing the caseload and hence waiting time for specialist services at HA hospitals. Repeated investigations into the disease/medical history could be avoided with the help of electronic health record sharing.</p>

Figure 4.14 (Cont'd)

Service Gaps

3. Post-diagnostic Support –Service providers have different views on the service model of dementia care and thus the service delivery deviates. Information, advice and counselling are not readily accessible by patients and carers on prognosis, treatment options and the future handling of their welfare and financial matters. There is also a need to enhance the support for patients and their carers to manage crisis and get them prepared for the trajectory of functional and cognitive decline as the patients move through each stage of the disease.

4. Co-ordination & Care Management
- A more standardised protocol on dementia care needs to be developed. Patients with multiple needs and co-morbidities often have to navigate among service providers because of little co-ordination and unclear pathways of referral. Service planning does not fully cater for the needs of the elderly in the neighbourhood. Patients with different levels of functional impairments may have to travel to other districts for services they need.

Bridging the Gaps

➤ **Post-diagnostic Support** - Patients with dementia often have multiple needs. Effective coordination of ongoing medical and social support after diagnosis is vital for achieving improved quality of life for persons with dementia and their carers. Development of a widely recognised service model is needed. More information and advice should be given to them on the availability of treatment options and support services. Clear pathways of referral should be made available to patients and their carers so that they know where to seek help. Regular reviews and case management meetings should be conducted to modify care plans if necessary. The setting up of a hotline may be useful to help carers in time of crisis and needs. Non-drug intervention by allied health professionals will help slow down disease progression and support from clinical pharmacists will help patients identify medication-related problems. Provision of more subsidised dementia drugs may be considered.

➤ **Co-ordination & Care Management** - There is a need to consider incorporating a case management approach for more complex cases to facilitate the coordination of resources and identification of special needs of patients. For better service planning, we should stock take the types of facilities available in each district and assess the demand in the neighbourhood. Establishing a database to share updated care plans and service outcomes will allow effective reviews and assessments of patients' conditions.

Figure 4.14 (Cont'd)

Service Gaps	Bridging the Gaps
<p>5. Community Services - Healthcare and community support services (including day care, respite services, outreach services, home-based services, etc.) need further enhancement to address the needs of the elderly with dementia and the carers.</p>	<p>➤ Community Services - There is a need to enhance dementia care services in the community and provision of dementia-specific services to meet the multiple needs of patients. The specific needs of patients with dementia should be taken into account in assessing their eligibility for social services. Regular training should be provided to carers.</p>
<p>6. Continuing Care - More support is required for patients who have reached a stage where they can no longer live safely and independently in the community.</p>	<p>➤ Continuing Care – To assist an elderly person with dementia to stay in the community for as long as possible, the provision of continuing care, involving both medical and long-term care services, is a stage that demands most resources and efforts. It is important that the community as a whole shares a common vision of dementia care. There is a need to strengthen both the medical and social support in the community to reduce premature admission of patients to hospitals and long-stay facilities, as well as to provide relief to carers. There is also a need to enhance co-ordination between hospitals, primary care sector/GPs and social service providers so as to facilitate discharge planning. A key issue in the provision of continuing care is how to achieve the flexibility necessary to respond to the particular needs of the person with dementia and their carers through effective coordination of services. Ongoing training should be provided to health and social care personnel, as well as carers.</p>

Figure 4.14 (Cont'd)

Service Gaps	Bridging the Gaps
<p>7. End-of-life Palliative Care - End-of-life palliative care is not widely understood among the public, patients with dementia, carers and healthcare professionals. Patients with severe dementia may have to undergo unnecessary hospital readmissions and invasive intervention that may not be conducive to maintaining their quality of life.</p> <p>8. Younger Onset Dementia – Public knowledge on dementia needs to be enhanced to facilitate early detection. There should be better accessibility to assessment and diagnosis services (such as advanced neuroimaging) and more treatment and supportive programmes should be provided for the patients and their family.</p>	<p>➤ End-of-life Palliative Care - There is a need to promote greater understanding and acceptance of end-of-life palliative care to facilitate patients and their carers to make informed decisions. There are problems including traditional values, customs, practical and legal issues involved in “dying in place”. This could be explored not only in the specific context for persons with dementia but also for all elderly persons.</p> <p>➤ Bridging the Gaps - Education for primary medical practitioners on the symptoms in younger patients. Easier access to secondary and tertiary diagnostic facilities is also beneficial to these patients. Medical-social collaboration would also contribute to the comprehensive care planning.</p>

4.4 Enhancing Dementia Care: A Person-Centered, Holistic Care Approach

4.4.1 Caring for persons with dementia is a responsibility shared among individuals, families and the community. Multiple players will get involved to provide different support and services to meet the multi-faceted needs of persons with dementia. The service delivery model should be person-centred and holistic in nature, having regard to the multiple and changing care needs of the individual. This requires close collaboration of service providers across multiple sectors, including medical, social, housing, police, education, etc., to ensure seamless integration of comprehensive services in a dementia-friendly community.

Principles of Care for Dementia

4.4.2 As with other elderly persons, the majority of persons with dementia would wish to remain in the community for as long as possible. To achieve this, there is a need to increase awareness, reduce stigma, facilitate early detection and intervention of the disease, and enhance community support to maximise elders' ability to live in their own homes and communities safely, independently and comfortably. It is also important to ensure that the service delivery model is comprehensive, holistic and person-centred covering the multi-faceted needs of patients. The model should also be accessible, individualised and responsive to the different care needs at different stages. This would require consistent and sustained support across the continuum of care in order to achieve good care outcomes for persons with dementia and their carers. Figure 4.15 shows the major principles of care for dementia.

Figure 4.15 Major Principles of Care for Dementia

In developing the service model of care for dementia, the following principles have been taken into account. These principles cover the needs of people living with dementia and their carers.

Community care approach

- Community care of dementia should be emphasised as studies have shown that admission of the demented to hospitals or residential care homes may hasten deterioration because the demented are prone to be more confused in new and unfamiliar environments. The aim of care for dementia is thus to help the demented stay at home as far as possible.

Multi-disciplinary approach

- Dementia is a complex problem. It causes disabilities in physical, mental, behavioural and social functioning. Effective intervention should aim at a holistic improvement and management of all these aspects.

Early detection and intervention

- They are the key to recognise the problem, facilitate access to service and effective management as well as to reduce stress both for the individual and the carers.

Person-centred and holistic care

- An individual suffers significant cognitive and physical impairments when the disease progresses to its severe stage, leading to a state of total dependence on others. Respect of the individual as a dignified human being is one of the major principles in care of dementia. We should also aim at maintaining the quality of life by maximizing residual functions of the individual. Care for the individual should be person-centred and holistic in nature having regard to the emotional, social, physical and spiritual needs of the person.

Support to carers

- Caring for a dependent family member with dementia is a demanding task and requires both physical assistance and emotional support.

Person-centred, Holistic Care

4.4.3 Persons with dementia require a continuum of integrated care. The care is given by multiple sectors and service providers across disciplines. The key elements and service players along the care pathway are discussed in the ensuing paragraphs.

Public Education

4.4.4 Public education and efforts to raise awareness can occur at multiple levels and places. Education, health and social care authorities all have a role to play. From schools to community centres, territory-wide awareness-raising efforts will improve the public's understanding of dementia and change public attitudes. Public education is also conducive in creating a dementia-friendly environment which would in turn enable persons with dementia and their families to be in a stronger and better-informed position to seek help, plan for the future and make more appropriate use of health and social services.

Medical Care

4.4.5 Contributing to healthy ageing is a healthy lifestyle and reduction of exposure to risk factors. Good health maintenance and assessment will enable symptoms of dementia to be detected early. Persons with dementia and their families may feel helpless and lost after diagnosis of dementia is confirmed. The physician who makes the diagnosis should therefore provide the persons with dementia and carers with appropriate counselling and explanations of the diagnosis and treatment options. Ready access to affordable medications is essential and the management of other medical co-morbidity will have a positive impact. While primary care physicians can take up a bigger role in the early diagnosis of dementia, specialist out-patient clinics can offer early diagnosis and management of complex or atypical cases of dementia. As dementia progresses, behavioural and psychological symptoms of dementia (BPSD) can cause serious distress to carers and affect the quality of life of a person with dementia. Specialist treatment (for example, by psychogeriatric teams) for BPSD management would therefore be needed. The specialist services could be provided through out-patient, outreach, day hospital or in-patient care. For persons with severe dementia, quality palliative care should underpin all care at this stage to assist the person with dementia to decease with dignity and comfort.

Social Support and Care

4.4.6 To allow persons with dementia to remain in the community for as long as possible, home-based support, home-assisted living, elderly day care, as well as dementia-friendly facilities in the neighbourhood will add to quality of life. Elderly centres are valuable resources in society for providing support to persons with dementia, enabling them to maintain reasonably healthy and active social lives. Well-constructed, evidence-based, non-drug programmes with a view to delaying the cognitive and functional decline of persons with dementia should be put in place in elderly centres where feasible to assist in the maintenance of cognitive and functional capacities. Home modification would be needed and families and carers should be counselled on ways of modifying the place of living to reduce exposure to danger. As the level of dependency continues to increase when the disease progresses, persons with dementia will need continuing care in long-term care facilities. Dementia-friendly facilities that are built around the needs of persons with dementia will give as much privacy, dignity and autonomy of the persons with dementia as possible. Quality nursing and personal care in quality places are also essential.

Other Community Support Services

Housing Services

4.4.7 The first step to enable persons with dementia to age in place is to provide them with a dementia-friendly community. These include removing risk factors (e.g. removal of harmful substances and sharp objects at home) from their daily surroundings. The design of housing should also be made friendly (e.g. mounting clear signs at the right height, using contrast to highlight or conceal, making things such as the contents of cupboards visible and easy to understand, etc.) to facilitate persons with dementia.

Police

4.4.8 The education of non-health-related professions such as the police, security guards, etc., should be undertaken to create a more accepting, tolerant and supportive neighbourhood. Training should also be given to them to enhance their understanding of dementia and the behaviour of those who may lose independence and capacity. This will enable them to better understand the

needs of persons with dementia and their families. Stories of persons with dementia gone missing from home are not unheard-of, and the police will play an important role in helping reunite persons with dementia with their loved ones.

Legal Protection

4.4.9 Persons with dementia and their family members should be informed of the options to appoint a guardian or an attorney to make financial, legal and healthcare decisions for them when they are able to do so. This will ensure that the wishes of the persons with dementia are respected.

Capacity Building and Workforce Training

Workforce Planning and Training

4.4.10 In the light of an ageing population and rising demand for dementia care, there is a need to ensure an adequate supply of multi-disciplinary healthcare professionals and skilled social care personnel to provide different types of care for meeting the varying needs of patients. Structured training on dementia care should be given to empower these care providers such that they become proficient in detecting symptoms, as well as in understanding the disease trajectory and approaches to care.

Support to Informal Carers

4.4.11 As informal carers usually take up the primary role in taking care of persons with dementia, training and education can help carers recognise signs of illness and reduce stress. Informal carers would need information and advice on where to seek help and how to care for persons with dementia. Organised information is in particular important and valuable to carers as they encounter an array of interfaces along the continuum of care. Respite care, grieve and bereavement support are also essential elements in enabling these carers to continue in their role. Financial assistance may be needed in the case of carers from low income families.

Research and Prevalence Studies

4.4.12 As dementia is among one of the most disabling chronic diseases, it is important to invest in research that will generate knowledge about what interventions are effective, and how to translate what we know into actions. It is also important to identify priorities and milestones in dementia care so that all service providers will work towards the common goals. Prevalence studies and research on effectiveness will provide reliable insights in service planning.

Dynamics of Existing Services

4.4.13 The concerted effort of the abovementioned components and sectors leads to the integrated nature of the existing care for persons with dementia. Figures 4.2 presents the dynamics in the form of an interactive diagram for easy understanding.

Figure 4.16 Typical Service Components for Persons with Dementia

	Mild Dementia	Moderate Dementia	Moderate Dementia with BPSD	Severe Dementia
Medical Sector	Public education and awareness			
	Health maintenance and assessment	Specialist consultation	Specialist treatment for BPSD management	Specialist treatment
		Pharmacological interventions		Palliative care
	Medical-legal issues management			
	Carer training			
	GP training			
Social Service Sector	Public education and awareness			
	Psychosocial care personnel training			
	Centre-based services for socialisation & elder learning programs (e.g. exercise classes, games)	Centre-based services for socialisation programs (e.g. exercise classes, games)	Dementia-friendly residential care services for individual, holistic care	
	Cognitive training programs (evidence-based programs)	Opportunistic screening of functional impairment, training & non-pharmacological interventions		
	Long-term care assessment & service referral			
		Day care & home care training & support for individual, holistic care	Dementia-friendly day care facilities for BPSD management	
	Dementia friendly design in long-term care settings			
	Carer training & support			
Counselling				
Housing Service	Dementia friendly housing & local community			
		Home modification		
Police	Missing persons support services			
Guardianship Board	Telephone advisory service	Guardianship order		
Education	School curriculum and training programs for care professionals			
Research Institutions	Prevalence and research statistics			

4.5 Integrated Community Care and Intervention Model for Dementia

4.5.1 The gaps identified in the previous chapter suggest that people living with dementia may not always have easy access to the services they require. In a bid to improve the current situation, the Expert Group has taken a fresh look at the delivery model. The existing delivery model adopted is one that emphasizes multi-disciplinary support including community care. However, inefficiency exists at various points along the continuum of care due to fragmentation of services. The Expert Group embraces the principle of giving persons with dementia the choice of remaining in the community for as long as possible. To allow this to happen, there is a need to develop a refined model which seeks to align and integrate medical and social services, while making better use of public and private resources and expertise. There is also a need to address existing bottleneck in the public healthcare system by transferring stabilised cases of dementia into community care, thereby allowing more effective use of specialist resources in the management of complex cases.

Intervention for Mild and Moderate Dementia

4.5.2 Dementia is a chronic condition spanning over decades. While symptom manifestations usually get more complex with increasing severity of disease, the early phases are mainly characterised by milder cognitive impairment and behavioural symptoms. With good medical-social support in the community, quality of life and functioning level for people with dementia would hopefully be improved.

4.5.3 With a projected high volume of people reaching old age in Hong Kong, the prevalence of people with dementia is expected to rise significantly in the coming decades. The Expert Group considers that it is important to develop an intervention model for attending to persons with mild or moderate dementia in the primary care and community setting if the provision of dementia care is to be sustained.

Objectives of the Model

4.5.4 The primary objective of this model is to offer an integrated intervention framework for people with mild or moderate dementia in the early phase. Services should be provided in the primary health and social care settings, with an aim to optimising the cognitive and functional abilities of targeted users in the community living groups.

4.5.5 Intervention is based on the recent empirical evidence that good cardiovascular health and lifestyle modifications may have beneficial effects on maintenance of cognition and prevent frailty. Additionally, with regular medical support, dementia symptoms and other associated chronic medical conditions could be stabilised at the earliest possible time. We also recognise the need of bilateral support, i.e. the integrated support by healthcare professionals at primary care level and specialists support as well as care at community settings. Figure 4.17 illustrates the service framework of this model.

Early Assessment of Suspected Cases of Dementia

4.5.6 Service recipients with memory loss and suspected cognitive impairment can be offered the option to attend initial assessment for cognitive function at elderly service units by a trained professional (such as doctor, nurse, occupational therapist, etc.). Those who have clinically significant cognitive impairment but have not been put under regular medical care would be referred for further medical evaluation by visiting primary care physicians serving the elderly service units or GPs with training at private clinics in the community. If further tests (such as neuro-imaging) are required to confirm the diagnosis, the patient could be referred to a specialist and/or a community laboratory for investigation.

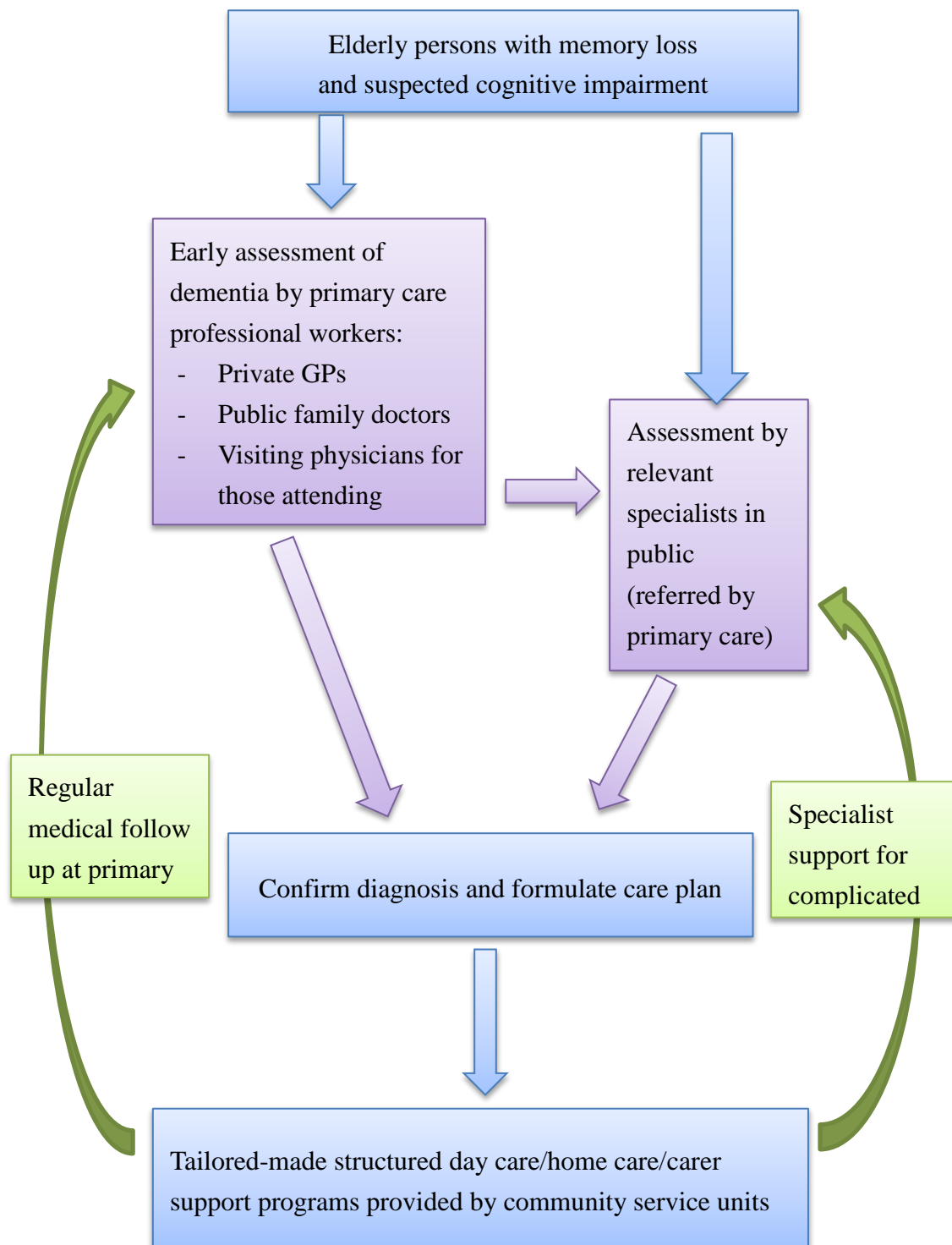
Management and Support for Confirmed Cases of Dementia

4.5.7 Once the diagnosis of early phase dementia is confirmed, suitable services should be provided to persons with less complex symptoms to help delay their cognitive and functional decline. Regular medical follow-up should be conducted by visiting primary care physicians serving the elderly service units or GPs with training at private clinics in the community.

4.5.8 Apart from medical treatment, persons with dementia should be advised to attend structured lifestyle activity programmes at the elderly service units, tailored for cognitive stimulation according to their global cognitive function. The activity training should be arranged by care personnel such as social workers/occupational therapists/physiotherapists of the centres. Psychosocial care should also be provided as it is beneficial to provide psychological support to newly diagnosed cases. With intervention given at an early phase, this may delay the functional and cognitive decline of persons with dementia, and hence enabling them to remain in the community for as long as possible.

4.5.9 While the management of persons with mild or moderate dementia is done by healthcare and social care professionals in the primary care setting, should their conditions worsen (e.g. when complex comorbidity develops) and require specialist attention, they should be referred for specialist intervention including hospital care and/or residential care services.

Figure 4.17 Care Pathway for Persons with Mild or Moderate Dementia



Capacity Building of Care Workforce

4.5.10 The intervention model for persons with mild or moderate dementia focuses on early identification and assessment of dementia, as well as intervention after early diagnosis. Effective implementation of this model counts on the expertise and skills of primary care physicians and social care professionals in the social care setting (e.g. social workers, nurses, occupational therapists, physiotherapists, programme assistants, etc.) in the management of people with dementia. Training programmes in medical and social disciplines need to be arranged so that there would be an adequate workforce ready for service delivery.

4.5.11 As the model involves a paradigm shift from the conventional compartmentalised way of delivering dementia care, pilot programmes are important for testing the readiness of service providers, with evaluation on clinical effectiveness, service statistics with cost economic analysis performed before full implementation. It is noted that community-based programmes could benefit dementia patients and their carer through providing early detection and support for persons with dementia (see examples of such community projects at **Annex F**).

Accelerated Care for Moderate to Severe Dementia

4.5.12 As the disease progresses, the cognitive and functional levels of persons with dementia continue to decline. Persons with dementia, especially those with behavioural and psychological symptoms, will need more intensive medical support from specialists (such as geriatric/psychogeriatric teams). They may also need more frequent acute and sub-acute medical services, such as out-patient, outreach, day hospital or in-patient services. A multi-disciplinary approach with individualised care plan should be adopted to improve quality of life of patients and decrease carer's stress. Non-pharmacological interventions should be the first-line interventions, with appropriate use of medication if indicated. Management of complex BPSD is labour-intensive and require well-trained multi-disciplinary staff.

4.5.13 Medical support aside, psychosocial care and community support, initially in terms of day care and later residential care, is important for people with moderate to severe dementia. The caring needs of persons with moderate and severe dementia in residential care are complex, and this is especially so for those with BPSDs and multiple co-morbidities & polypharmacy. Multi-disciplinary input and support might be useful in this regard. Mainstream residential services may not be sufficient to cater for the reduced cognitive capacity of persons with moderate and severe dementia. While the building of dementia-specific elderly homes may be constrained by the availability of land, one way to overcome the constraint is to introduce dementia-friendly modifications with design features that will cater for the cognitive decline of persons with dementia (e.g. clear signs and hallways to help orientation). In the longer run, dementia-specific facilities/units should be considered to address the complex nursing needs of a growing number of service users with complicated dementia.

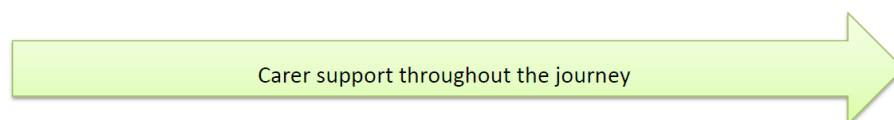
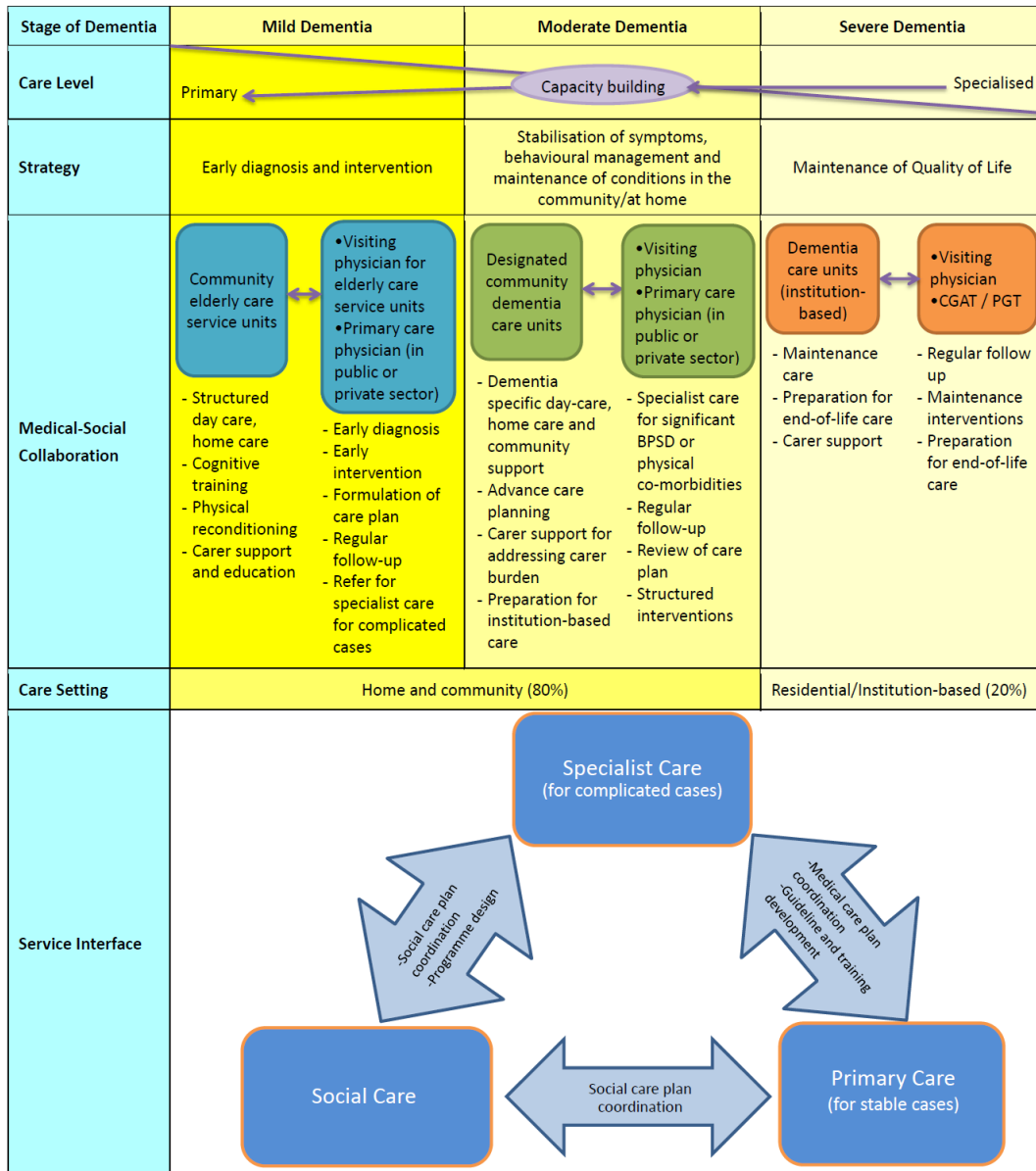
4.5.14 It is also worth noting that patients with dementia especially at old age may need admission to hospitals for treatment of infections such as sepsis, hip fracture, cardiopulmonary problems, etc. These patients are prone to developing delirium (on dementia) and recognition of the underlying diseases will thus require high clinical acumen. These patients may also be resistive to care and communication between the attending medical team and family members is important to prevent misunderstanding.

Medical-Social Collaboration

4.5.15 The intervention model for dementia as discussed above seeks to address the rising demand for dementia services in a more cost-effective and sustainable way. The model has a special focus on the early phase of dementia as it is believed that there exists a window of opportunity when intervention is most effective in delaying the cognitive decline and maintaining the quality of life of those suffering from dementia. Yet all persons with dementia and their carers have to traverse through a continuum of early to moderate to severe dementia. Although the needs, level of care and strategy required are different, effective medical-social collaboration is the key to achieving quality, cohesive, holistic and person-centred dementia services.

4.5.16 Figure 4.18 illustrates the different care levels, strategies, medical-social collaboration and care settings for those who are at different stages of dementia.

Figure 4.18 Medical-Social Collaboration in Dementia Care



4.5.17 In order for persons with dementia to stay in the community, it is important to enhance medical-social collaboration in providing community support. A coordinating platform at the district level (e.g. district coordination committee) involving health and psychosocial care professionals will allow services to be delivered in a more cohesive manner. In terms of care level, the district-based dementia-friendly model advocates for a strengthening of services at the primary care level. Joint efforts are required in the areas of early diagnosis, stabilising symptoms, managing conditions, as well as provision of medical and social support to maintain optimal quality of life for persons with dementia. As the disease progresses, persons with moderate to severe dementia will need home support, respite care, outreach medical services. They will also benefit from advance care planning on legal, financial and healthcare matters. When the person enters the severe stage of dementia, they will begin to rely more on institution-based care (e.g. residential homes, hospitals) and more intensive specialist services. Carer support is also an important part of the model and their inputs will be sought from time to time in formulating and revising the treatment plans for the patients. The ultimate goal is to utilise collaboration of NGOs, medical support at primary care level and specialist care to form an integrated support network for persons with dementia in the long run. Effective collaboration of different disciplines could reduce service gaps and avoid duplication of resources between various professions, as well as necessitate the required medical support. For each stage of dementia, the major role of primary support is to provide regular medical support. For complicated cases (for example patients with significant BPSD and/or multiple co-morbidities), referral should be made to appropriate specialties (such as geriatricians and psychogeriatricians) for further management and follow-up. Moreover, with a view to achieving aging in place, better quality of life and lessen carers' burden throughout the care pathway, appropriate community and social support (such as day care, home care, respite care and carer support/training) could be provided via suitable community care facilities.

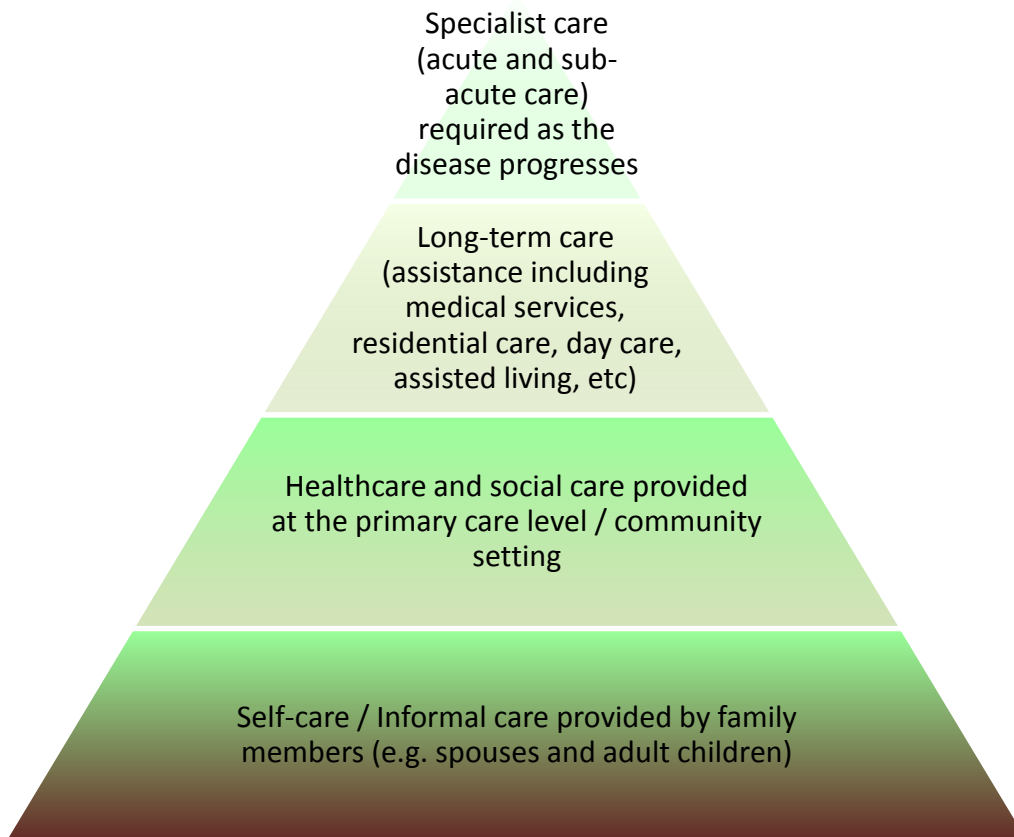
4.6 Recommendations and Way Forward

4.6.1 Dementia is an increasingly common disease in the community. It is however important to note that dementia is not part of normal ageing and there are actions that can be done to enhance our preparedness for this challenge. Whether new cases will be promptly identified and referred for appropriate services or go unnoticed and slip through the cracks of our medical and social systems depends on our overall approach to perceiving the disease and its impact, as well as in planning for services and managing care.

4.6.2 The Expert Group notes that dementia requires continuous medical as well as social care and support services. A coordinated cross-sectoral and multi-disciplinary approach is required to bring the best possible outcomes in its care. Social care services that support persons with dementia and their carers to facilitate the former to stay in the community for as long as possible play an equally important role as clinical diagnosis and medical treatment. Figure 6.1 illustrates the ideal care pyramid where individuals with multiple needs at different stages of the disease would receive the appropriate level of care. The ultimate goal behind this concept and in enhancing dementia care is to prevent and delay the onset of the disease where possible, and where not, to slow its progression so as to allow persons with dementia to age in place and die in place, and with dignity.

4.6.3 With this ultimate goal in mind, the Expert Group has put forward a package of recommendations to enhance dementia care. The recommendations underline the Expert Group's commitment to raising public awareness of dementia and strengthening care for persons with dementia through a comprehensive array of services ranging from prevention, intervention to social support in the community.

Figure 4.19 Dementia Care Pyramid



Recommendations

1. ***Public education should be strengthened to promote healthy lifestyles, better understanding and awareness of dementia, encourage help-seeking behaviour and reduce stigma associated with dementia.***

The Expert Group recommends that public education campaigns should be developed by the Government to address a wide range of issues and audiences including early warning signs and effective strategies for obtaining diagnosis, treatment and support, along with other efforts to promote healthy lifestyles including regular physical activities. The Department of Health should adopt a proactive approach in public education to raise awareness of the disease and emphasize the importance of modifiable risk factors when promoting the adoption of healthy lifestyle practices. DH and SWD should compile and disseminate information on health education and community resources

available respectively to help people living with dementia and their carers so that people know more about the disease and where to seek help and what sort of services are available.

Effective prevention approaches in education settings are equally important. The school curriculum already supports learning about mental well-being and healthy lifestyle. Dementia as a theme can also be added to the curriculum to increase the right exposure of young people to dementia.

To reduce stigma associated with dementia, it is necessary to promote consensus on the adoption of a common Chinese nomenclature of the disease. Among all commonly-used Chinese nomenclatures, the Expert Group recommends the adoption of 認知障礙症, which is considered to have the least stigmatizing effect.

2. ***Territory-wide prevalence studies of dementia should be conducted regularly to inform service planning.***

To facilitate service planning, territory-wide prevalence studies of dementia should be conducted regularly and where possible, with details on the prevalence by district and the severity of disease by age group. It would be useful to establish common data collection tools and map out the prevalence of dementia by district and the corresponding service needs by looking at the demographic and socio-economic profiles of elders residing in the district. Planning and allocation of resources would be more cost-effective as a result. By collecting data on the severity and age of persons with dementia, the studies would enable us to account for the changes in service needs of different cohorts of patients over time as a result of progression of disease and changing demographic structure such as educational attainment levels of our future older generations.

3. ***A common reference should be developed to support primary care professionals on the diagnosis and management of dementia.***

The Hong Kong Reference Framework for Preventive Care for Older Adults, developed by the Task Force on Conceptual Model and Preventive Protocols under the Working Group on Primary Care, consists of a core document supplemented by a series of different modules addressing various aspects of disease management and preventive care. A dedicated module on dementia is recommended to promote international best practices and support decision-making by healthcare professionals in primary care on the diagnosis and management of dementia.

4. ***The role of primary care in the provision of dementia care should be enhanced through capacity building.***

Detection and diagnosis of suspected cases and management of stable cases are two important functions of primary care in the provision of dementia care. Early identification and referral of complicated cases to specialist services by primary care is to be encouraged at the stage when there is a possibility of beneficial intervention. Systematic training should be encouraged for GPs in the private practice so that they will become important care service providers. Colleges under the Hong Kong Academy of Medicine and training institutes (such as the University of Hong Kong, the Chinese University of Hong Kong, HKMA, etc.) which organise relevant courses at present could be the service providers and encouraged to provide training to GPs in future. On the other hand, HA should also explore the possibility of public-private partnership in the provision of dementia care by referring stable cases of dementia to private GPs. The enhancement of the role of primary care professionals in the provision of dementia care will reduce dependence on specialist care and allow scarce resources to be used optimally. Having a strong foundation of primary care will allow the dementia care pyramid (Figure 6.1) to function effectively.

5. ***The capacity of specialist services in HA should be strengthened to facilitate timely intervention of dementia cases through the implementation of a refined intervention model, with a view to reducing the waiting time of specialist services.***

HA should strengthen the capacity of specialist services (for example, geriatric and psychogeriatric support) through enhancement of its multi-disciplinary manpower having regard to service demand (such as the management of BPSDs which is complex). It should also review the caseload and profiles of patients and refer patients with mild or moderate dementia to the primary care setting so as to spare specialists with more time for handling complicated cases. It will also reduce the waiting time of specialist services and ensure that the right level of care will be given to patients in need promptly.

6. ***There is also a need to increase the supply of healthcare manpower and strengthen their training. Training for healthcare and social care providers should be enhanced so that they are equipped with the necessary skills and knowledge in providing care to persons with dementia.***

Dementia care is a labour-intensive task. With increasing demand for dementia services, there is a need to ensure an adequate supply of multi-disciplinary healthcare professionals and skilled social care personnel to provide different types of care for meeting the varying needs of patients. Elderly and dementia care should be featured in the relevant training programmes provided by the education sector so that healthcare and social care professionals will become proficient in detecting symptoms, as well as in understanding the disease trajectory and approaches to care. Regular on-the-job training should be mandated for healthcare and social care professionals to ensure their continuing competence.

7. ***Social care infrastructure should be strengthened to allow persons with dementia to remain in the community for as long as possible.***

To allow persons with dementia to remain in the community for as long as possible, dementia-friendly neighbourhood should be encouraged. Dementia-specific services in existing long-term care facilities (and dementia-specific units in the longer run) should be encouraged where possible to cater for the specific needs of patients, especially those with BPSDs. These facilities are preferably supported by specialist services for more optimal management of BPSDs. An existing coordinating platform (e.g. District Coordinating Committee on Elderly Services convened by SWD in respective districts) involving healthcare and social work professionals and other stakeholders in the district could be made use of to enhance liaison and exchange of information on dementia, as well as to discuss effective strategies for developing a dementia-friendly neighbourhood as necessary.

8. ***There is a need to enhance medical-social collaboration and further integrate the delivery of healthcare and social care interventions to provide patient-centred support.***

The implementation of an integrated community care and intervention model for mild or moderate dementia (for details please see Chapter 5) will allow mild or moderate cases of dementia to be managed at the community level through enhanced medical-social collaboration. Appropriate level of care will be given to patients with different needs. The collaboration over the delivery of healthcare and social care interventions will ensure that patients' multiple needs will be taken care of. The Expert Group recommends that a pilot be designed to test the feasibility of the care model.

9. ***End-of-life care and palliative care in the community setting should be promoted to minimise unnecessary and repeated hospitalisation.***

The concept of advance care planning and advance directives should be further promoted so that elderly persons, irrespective of whether they suffer from dementia and their families know about their options, could plan ahead according to their own wishes and values if circumstances so permit.

End-of-life and palliative care including the option to “die in place with dignity” should be studied for elderly persons, irrespective of whether they suffer from dementia, having regard to the socio-economic characteristics of our population and economy, as well as the legal and practical issues involved in the Hong Kong context.

10. ***Support for carers should be enhanced. This includes providing them with structured and accessible information, skills to assist in caring, respite to enable engagement in other activities so that they can continue in their role effectively.***

Most care for persons with dementia is provided by informal, unpaid family carers who include spouses and adult children. The support of families and informal carers plays an important part in enhancing the quality of life of persons with dementia. The responsibilities of informal carers can exact a high price on their physical and emotional health. The development and provision of a range of programmes and services (say, through NGOs) to assist family carers and reduce their strain should be encouraged. Information including understanding the characteristics and course of the disease as well as what resources are available to families, along with training in how to care for people with the disease and how to lessen and deal with behavioural symptoms, should be provided to carers and NGOs that provide elderly services. Respite care (for example, home respite service), counselling, long-term support should be encouraged and provided to carers to enable them to continue in their role effectively for as long as possible. The establishment of carer support groups should be encouraged as carers could seek advice and share the problems and challenges encountered in taking care of persons with dementia

through the groups. Applying innovative technology in the provision of dementia care services (for example, using Apps to provide information and tools that can facilitate carers to take care of persons with dementia) should also be encouraged to enhance the carer support.

Way Forward

4.6.4 Improving dementia care requires combined efforts of all stakeholders over a sustained period and cannot be driven by the Government alone. Actions to promote awareness of dementia and address its care needs cut across different policy areas, service sectors and settings. As individuals, one needs to adopt a healthy lifestyle and look after one's own health as risk factors such as smoking and obesity may increase the risk of dementia. Society as a whole also needs to be more accommodating, supportive and non-discriminatory towards those with dementia.

4.6.5 In view of the trend of promoting innovation and technology in the community, applying more innovative technology in the provision of dementia care services should also be encouraged with a view to streamlining the labour-intensive operation of elderly centres/homes, facilitating the health and social care professionals and frontline workers to perform their daily work more effectively and attracting more new blood, in particular young people, to join the workforce of dementia care in the long run.

4.6.6 Raising awareness, building capacity and creating a dementia-friendly environment will take time. This report does not mean to prescribe a panacea for all. Rather, it seeks to underline the challenges ahead so that we can get prepared for them. The observations and recommendations seek to outline a common vision for enhancing dementia care. Instead of being prescriptive in the way about what and how services are to be delivered to persons with dementia, we hope the report can provide a broad roadmap to guide future efforts in enhancing dementia care. Dementia care is a shared responsibility of all. It is our belief that with concerted efforts of the community, persons with dementia will age with dignity and enjoy a better quality of life.

Chapter 5 – Applicability and Practicability of Introducing Community Treatment Order (CTO) in Hong Kong

5.1 Introduction

5.1.1 Following a high profile tragedy involving patient with SMI, the proposal to introduce CTO in Hong Kong came to light. The Review Committee has looked into the applicability and practicability of introducing CTO in Hong Kong and has put forth its recommendation on the issue, after considering all relevant factors including overseas experience in using CTO as a legal instrument for compelling people with mental illness to receive psychiatric treatment in the community.

5.1.2 A CTO, or involuntary psychiatric treatment in the community, is a legal provision mandating a person with mental illness who meets specified criteria to follow a prescribed course of treatment while living in the community, non-compliance of which may cause the person to be recalled to a hospital for treatment. It is intended for persons who suffer from serious mental disorder, who do not voluntarily take prescribed medications or for whom compliance is problematical, and as a result are unable to maintain their own health and safety or become dangerous to others. As an alternative to hospital admission or continuing detention in a psychiatric hospital, CTO seeks to compel psychiatric treatment for such patients outside the hospital setting and in the least restrictive environment, thereby ensuring the health and safety of the individual as well as that of the general public.

5.1.3 CTO regimes operate in a dozen or so economies, including the United States, Canada, the United Kingdom, Australia, New Zealand, Belgium, Luxemburg, Portugal, Sweden, Norway, Israel and Taiwan. CTO regimes were first developed in North America and Australasia in the 1980s for the treatment of the mentally ill following deinstitutionalization of mental health services, and introduced into Europe in the 2000s. CTO comes in different names and forms, and the varying design across jurisdictions often reflects the constitutional, social and legal contexts in which the relevant legislation is enacted.

5.2 Overseas Experience

General Design of Community Treatment Order

Diversionary vs Preventive Model

5.2.1 Broadly speaking, there are two basic CTO models. The first one is a diversionary (or least-restrictive) model in which the patient being subject to a CTO must meet criteria identical to that for compulsory admission. It can be viewed as an alternative to compulsory treatment in the restrictive hospital setting. The second model is a preventive model in which a patient who has not deteriorated to the point of meeting the criteria for compulsory admission can be put on a CTO (i.e. separate criteria from that for compulsory admission). The objective is thus to prevent deterioration from occurring. The CTO arrangements of many jurisdictions share the features of both models.

Criteria for a CTO

5.2.2 Generally speaking, two sets of criteria are established by the relevant legislation to govern a person's placement on CTO: general criteria governing one's placement under the legislation as a whole; and more specific criteria governing the use of involuntary outpatient care. The general criteria usually specify the forms of mental disorder for which involuntary treatment may proceed, and the necessary "harms", "dangers" or "risks" the person must pose to his own health or safety or that of others. The more specific criteria usually require that outpatient treatment be "appropriate" or "viable", and that adequate community services be "available" to meet the person's needs. The latter criteria can be very precise in some states, say, specifying that involuntary outpatient treatment may only be used as an alternative to hospital, or that a certain number of recent hospital admissions is required.

The Role of Competency (or Capacity) Principle

5.2.3 The principle concerns whether involuntary psychiatric treatment can be provided to a person who retains their competence to consent (or their capacity). While some patients lack the competence to consent to treatment throughout their time on CTO, some may regain their competence while they are still under the order, or their competence may fluctuate during the course of their care.

5.2.4 In North America, the general position is that psychiatric treatment cannot be provided without consent by a competent patient, even if the patient is lawfully placed under a CTO. Apart from prohibiting involuntary psychiatric treatment to patients who regain their competence, the principle also requires clinicians to assess the competence of involuntary patients on a regular basis, to ensure competent patients are not being treated without their consent. This approach leads to a lower rate or length of use of CTO as compared with regimes not based on the competency principle.

5.2.5 In the United Kingdom and Australasia, the general position is that psychiatric treatment may be provided without consent by a patient as long as he remains lawfully under the CTO. As a matter of law, the patient's resumption of competence does not suspend the responsible clinician's authority to treat that patient without consent. Nor does return of the patient's competence trigger an immediate right to their discharge from a CTO. This approach permits the continuing treatment of patients with severe and continuing mental disorders, whose competence may fluctuate, but for whom a sustained course of medication may be required.

Previous Hospitalisation

5.2.6 The second major fault-line concerning the criteria for CTO relates to whether a person must have a history of prior hospitalisation to be subject to a CTO. The requirement varies between jurisdictions. In North America, for a CTO to be employed, the Saskatchewan legislation requires that during the immediately preceding two-year period, the person must have been detained in an in-patient facility for a total of 60 days or longer, or have been detained in an in-patient facility on three or more separate occasions. Similarly, the Ontario legislation requires the person to have been hospitalized at least twice, or for more than 30 days, in the last three years. Neither of these requirements prohibits the use of a CTO following a first admission, but only a lengthy first admission would meet the criterion laid down. On the contrary, the legislations in Victoria and New South Wales of Australia, New Zealand and Scotland make no reference to prior hospitalisation at all.

Powers to Enforce Treatment in Community Settings

5.2.7 Another fault-line in CTO design concerns the precise scope of treatment powers conferred on clinicians. There are two general approaches. The first (known as first-generation CTO) is for the legislation to confer explicitly on health professionals a package of powers that may be used at their discretion to facilitate the treatment of the patient under a CTO. In other words, powers are directly conferred: to enter private premises; to provide treatment; to recall the patient to hospital; to use reasonable force in the process of recall; and to obtain police assistance, etc. This approach has the advantage of being transparent and simple.

5.2.8 The second approach (known as second-generation CTO) is adopted in more recent years. CTO legislation under this approach requires the formulation of a statutory treatment plan for each patient. The precise powers conferred on healthcare professionals to enforce community treatment are thus specified indirectly. This approach is less transparent, but more sophisticated and calibrated.

Rate of Use and Therapeutic Relationship

5.2.9 A review of international research literature reveals that CTO remains a contested issue in psychiatry with mixed stakeholder perceptions and inconclusive findings about their efficacy. Supporters consider CTO useful in attempting to address some major difficulties encountered in the management of those with a serious mental illness and a tendency of non-compliance with voluntary treatment. However, some fear that it would damage therapeutic relationship and undermine non-coercive efforts to engage patients. The threat of forced treatment may cause people to avoid services altogether.

5.2.10 Rates of CTO use vary considerably, and are relatively higher in some Australian states and lower in Canada.⁷¹ How often CTO is used depends on their design, the adequacy of intensive community services, and the perception of clinicians. A lower rate of use in some jurisdictions in North America, for instance, is attributable to the more restrictive design of their CTO regimes which – contrary to the Australian model – require a previous history of hospitalisation

⁷¹ According to a review conducted by Lawton Smith S of the King's Fund in London in 2005 - *A question of numbers: the potential impact of community-based treatment orders in England and Wales*.

for one to be subject to a CTO and prohibit involuntary psychiatric treatment to patients who regain competence. A higher rate of use in Australia is also due to the receptiveness of clinicians who consider CTO a useful strategy in managing the transition of long-term psychotic patients between hospitals and community, whereas a lower rate in Canada is due to concerns about clinicians' liability for negligence or failure in treating or supervising patients placed under CTO.

Effectiveness and Efficacy

5.2.11 Notwithstanding increasing use of CTO, their efficacy remains unclear. Research studies have failed to conclude whether CTO is beneficial or harmful, and there is inconsistent evidence about the effects of CTOs on clinical and quality-of-life outcomes. Some studies suggested that the use of CTO might reduce the risk of violent behaviour, yet others found no discernible reduction in homicide rates by people with mental illness.

5.2.12 Over the past decades, only a few experimental studies have been conducted to assess the effectiveness of CTO using the gold standard of randomized controlled trials. Of the three randomized trials published thus far, two were conducted in the United States (released in 1999 and 2001)⁷² which found no clear advantage to CTO in terms of reducing hospital admission in patients with a diagnosis of psychosis. In the first United Kingdom-based randomised trial to test CTO, published in March 2013 in *The Lancet*, researchers led by Professor Tom Burns from the University of Oxford⁷³ found that in well-coordinated mental services the imposition of compulsory

⁷² Swartz MS et al. Can involuntary outpatient commitment reduce hospital recidivism? Findings from a randomized trial with severely mentally ill individuals. *Am J Psychiatry* 1999;156:1968-75. Steadman HJ et al. Assessing the New York involuntary outpatient commitment pilot program. *Psychiatr Serv* 2001;52:330-36.

⁷³ CTO for psychiatric patients became available in England and Wales in 2008. Led by Professor Tom Burns at the University of Oxford and funded by the National Institute of Health Research, the study, released in March 2013, examined whether CTO reduced hospital readmissions compared with use of pre-existing Section 17 "Leave of Absence" in the Mental Health Act (which allows patients to leave hospitals for some hours or days while still subject to recall, in order to assess recovery before granting voluntary status) when patients in both groups receive equivalent levels of clinical contact. The study recruited over 330 participants aged 18-65 years who were detained for inpatient treatment for psychosis in England between 2008 and 2011, and is reported as being the largest of its kind. Results from the trial showed no difference in the proportion of patients readmitted to hospital between study groups, nor in the time to readmission over a one-year follow-up. The overall duration of hospital care did not decrease nor did clinical or social functioning improve despite an average of six months additional compulsion. The researchers conclude that these findings have confirmed previous evidence that CTO does not confer benefits on patients with a diagnosis of psychosis, and their current high usage should be urgently reviewed.

supervision did not reduce the rate of readmission of psychotic patients. There was no support in terms of any reduction in overall hospital admission to justify the significant curtailment of patients' personal liberty. The findings have led to calls for review of the mental health legislation in the United Kingdom.

Enforcement Difficulties, Ethical and Human Rights Concerns

5.2.13 Apart from uncertainties about efficacy, there are concerns about the ethical justifications of CTO and its impact on human rights. CTO is intrusive and grant professionals powers to monitor a person's condition, provide non-consensual treatment, and take a person to a mental facility for treatment. Such powers interfere with a patient's civil liberties and human rights and raise a number of dilemmas for practitioners concerning consent, autonomy and paternalism, as well as confidentiality and privacy. Enforcing and monitoring involuntary community treatment is difficult and subject to inconsistency, arbitrariness or even abuse. While CTO places significant duties on governments to provide adequately resourced community mental health and accommodation services, there are concerns that scarce community resources will be diverted to support legally ordered services and weaken those available to patients not on CTO.

5.3 Compulsory Community Treatment in Hong Kong

Conditional Discharge Provision in Mental Health Ordinance

5.3.1 MHO (Cap. 136) was first enacted in 1960 to amend and consolidate the law relating to mental incapacity and the care and supervision of mentally incapacitated persons. Under Section 42B of MHO, a patient compulsorily detained under MHO⁷⁴ who has a medical history of criminal violence or a disposition to commit such violence may be discharged subject to conditions, such as to reside at a specified place, to attend out-patient treatment and to take medication as prescribed. The patient may be recalled to a mental hospital when he fails to comply with any discharge condition and the recall is necessary in the interest of his health or safety or for the protection of other persons.

5.3.2 Compared to CTO legislation in some jurisdictions, the conditional discharge provision under MHO has a more restrictive design, in that –

- (a) Conditional discharge applies to patients who are already under compulsory detention and treatment in a mental hospital⁷⁵. Patients who are admitted to hospital voluntarily could not be imposed any conditions upon discharge;
- (b) Patients to be put on conditional discharge have to meet the requirement of having “a medical history of criminal violence or a disposition to commit such violence”. Patients with strong suicidal risk or high chance of self-neglect do not fall into this category;
- (c) A conditionally discharged patient may be recalled to hospital if he has failed to comply with any of the specified conditions and the recall is necessary in the interest of the patient’s health or safety, or for the protection of other persons. A patient who relapses but has not breached any conditions could not be recalled directly, unless with a

⁷⁴ An order for compulsory admission to hospital is made by a District Judge or magistrate. An application for an order by the Court has to be founded on the written opinion of a registered medical practitioner, who must be satisfied that the admission is justified by the nature and degree of the mental disorder and is necessary in the interest of the patient’s health or safety or for the protection of other persons.

⁷⁵ In some jurisdictions in North America, CTO only applies to those with a previous history of hospitalisation.

fresh order from the court for compulsory admission under the Ordinance; and

- (d) MHO does not provide for any limit in the duration of which a patient could be put on conditional discharge. Patients on conditional discharge have to appeal to the Mental Health Review Tribunal for a review of their cases, or obtain approval of the medical superintendent after being checked by the case medical officer, if they wish to revoke the initial court order for hospitalisation. However, unlike cases of compulsory detention in hospital, the MHO does not stipulate any review period.

Application of the Conditional Discharge Provision

5.3.3 In 2015, 16 988 admissions were recorded for the psychiatric inpatient wards of HA, of which 2 968 were compulsory admissions. Among those involuntarily admitted, 152 patients with a medical history of criminal violence or a disposition to commit such violence were discharged conditionally under Section 42B of MHO. Patients on conditional discharge are put under the care of the Crisis Intervention Team or Case Management Programme of HA and provided with the necessary treatment and support to help them reintegrate into society. 23 patients on conditional discharge were recalled to hospital in 2015. Detailed statistics on the application of the conditional discharge provision are set out in Figures 5.1 and 5.2.

Figure 5.1 - No. of Involuntary Admission and Conditional Discharge

Year	Total Admissions	Compulsory Admissions		Conditional Discharges**	Patients on Conditional Discharges Recalled to Hospitals
		New*	Old*		
2015	16 988	956	2 012	152	23
2014	16 752	887	1 917	141	21
2013	17 298	928	1 734	162	35
2012	16 554	863	1 706	131	16
2011	15 336	786	1 585	135	27

* New cases refer to patients who had not received any psychiatric services at the HA in the previous two years, while old cases refer to those who had received psychiatric services at the HA in the previous two years. These compulsory patients include patients with a medical history of criminal violence, a disposition to commit such violence, patients with suicidal risk, etc.

** Conditional discharges are applicable to compulsory patients with a medical history of criminal violence or a disposition to commit such violence

Figure 5.2 - Snapshot of Patients on Conditional Discharge

Duration (as at 30 June 2015)	No of Patients on Conditional Discharge
Less than 90 days	28 (8%)
91 to 180 days	28 (8%)
181 to 365 days	29 (8%)
>1 year to 2 years	70 (19%)
>2 years to 3 years	44 (12%)
>3 years to 5 years	85 (24%)
>5 years to 10 years	66 (18%)
More than 10 years	11 (3%)
Total	361 (100%)[^]

[^] The percentages do not add up due to rounding

5.4 Considerations for/against introducing CTO in Hong Kong

5.4.1 As the case in many jurisdictions, the debate on whether there is a need to introduce CTO in Hong Kong arises from high-profile tragic incidents involving people with severe mental illness. Following the Kwai Shing East Estate incident in May 2010⁷⁶, a review committee of HA recommended, among other things, the Administration to study further the applicability and practicability of CTO in Hong Kong.

5.4.2 Arguably, deinstitutionalization has increased the number of challenging patients in the community. As we move towards a modernized community-based model in psychiatric treatment as in other developed countries, an option of involuntary treatment in the community would help healthcare professionals to engage high-risk patients in the rehabilitation process and promote medication adherence.

5.4.3 On the other hand, a proposal for introducing CTO would raise concerns on human rights issues. While the existing conditional discharge provision is confined to compulsorily detained patients, introducing a broader CTO scheme such as the Australian model covering compulsorily detained patients, patients admitted to hospital voluntarily and even patients without a history of hospitalisation would drastically expand the pool of patients to be subject to compulsory treatment in the community. There would be concerns over curtailment of civil liberties, possible abuse of power by healthcare professionals in compelling patients to receive treatment (e.g. take medication that may cause significant side effects) and intrusion into the privacy of patients (e.g. effective monitoring of patients on CTOs would require continuous communication of patients' conditions among frontline workers of different service providers and enforcement agencies).

5.4.4 Pressure for CTO legislation often arises from the mistaken belief that mental disorder predisposes people to behave violently. However, it is important to note that CTO is no silver bullet for eliminating tragic incidents

⁷⁶ A 42-year-old man chopped neighbours, a security guard and two housing estate officers, causing two deaths and three injuries at Kwai Shing East Estate on 8 May 2010. The man had a known history of mental illness. He was admitted to Kwai Chung Hospital in September 2004. After discharge, he attended specialist out-patient clinic regularly and was followed up by community psychiatric nurses until the occurrence of the tragic incident.

involving mental patients. The introduction of CTO would also increase stigma of mental illness and might turn patients away from seeking help.

5.5 Recommendations and Way Forward

5.5.1 The Review Committee noted that the introduction of CTO is a highly sensitive and complex issue involving considerations from different perspectives. In the absence of solid evidence to prove the efficacy of CTO, the Review Committee is unable to conclude that the benefit to derive from CTO will more than compensate for the curtailment on civil liberties or that the occurrence of tragic incidents involving mental patients will be reduced as a result.

5.5.2 As Professor Tom Burns of the Oxford University, who has seen through the development of CTO legislation in England and Wales, has pointed out, in considering changing the mental health legislation that might have significant impact on civil liberties, the question to ask is whether there would be a group of patients who have been poorly served by the present legislation, who are repeatedly subject to compulsory admission, and whose welfare would be better served by a CTO. Given the contention over the usefulness of CTO and its far-reaching implications, the Review Committee considers it prudent to further study the applicability of CTO in Hong Kong when needs arise.

More Effective Use of Conditional Discharge

5.5.3 The existing “conditional discharge” mechanism and the CTO have a common objective in that both seek to protect the health and safety of the patient and others in the community by way of mandatory treatment. However, the limited scope of patients to which the “conditional discharge” mechanism is applicable, as well as the prerequisite for pre-determined condition(s) under which a patient is released from hospital, has rendered it inefficacious in some scenarios. To further safeguard the health and safety of the patient and others in the community, we need to strengthen the existing “conditional discharge” mechanism. For instance, the scope of conditional discharge could be expanded to patients who have demonstrated strong suicidal risk, or patients who has deteriorated to a point that could endanger others but without breaching the discharge conditions. In this connection, HA will conduct a review on the “conditional discharge” mechanism.

Strengthening of the Case Management Programme for Patients with Severe Mental Illness

5.5.4 From overseas experience, the successful implementation of CTO requires adequate community mental health support in both the medical and welfare sectors. Community support services such as social rehabilitation would be necessary not only for patients themselves, but also their family members and carers. The Review Committee agrees that an adequate level of community mental health support is essential before patients with mental illness are discharged into the community.

5.5.5 In this connection, HA has launched the Case Management Programme in 2010-11 to provide intensive, continuous and personalised support for patients with severe mental illness. Under the Case Management Programme, a patient with SMI would be followed up by a designated case manager who would establish a close service relationship with the patient and develop an individual care plan having regard to the patient's needs and risk profile. The case manager would also provide intensive and personalised support for the patient throughout his/her recovery journey and work closely with various service providers, particularly the Integrated Community Centre for Mental Wellness, in providing a coordinated support to patients with severe mental illness in the community. After its successful pilot implementation, the Case Management Programme has been expanded to all 18 districts of Hong Kong in 2014-15. As at 31 December 2016, around 15 000 patients with SMI in the community were supported under the Case Management Programme, maintaining a ratio of case manager to patients with SMI at about 1:47. The Review Committee agrees that in the short and medium run, HA should conduct review on the ratio with a view to improving it to around 1:40 so that the case managers could provide better support to patients. In the long run, it is desirable to conduct further review on the ratio so as to bring about an optimal level of support and monitoring

Re-visiting the Applicability of CTO when Necessary

5.5.6 While the Review Committee considers that the introduction of CTO in Hong Kong is not appropriate at this moment, it suggests the Government to monitor the review of the “conditional discharge” mechanism and the enhanced Case Management Programme service, the prevalence of concrete evidence on the efficacy of CTO, as well as the public sentiment on patient management, and invite the standing advisory committee on mental health to re-visit the applicability of CTO in Hong Kong when needs arise.

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Summary of Effective Overseas Mental Health Promotion Programmes

Australia

Act-Belong-Commit Campaign

1. Act-Belong-Commit Campaign is a community-based campaign to promote positive mental health in Western Australia (WA) which is directed by Mentally Healthy WA at Curtin University. It has been launched since 2005 to encourage individuals to take action to protect and promote their own mental well-being and encourage organisations that provide mentally healthy activities to promote participation in those activities. The campaign provides simple behavioural guidelines (act, belong and commit) for the public to improve their mental well-being. The campaign combines a community development and social marketing approach to improve community understanding of positive mental health. The campaign targets individuals to engage in activities that enhance their mental health while encouraging campaign and community partners (e.g., health service providers, local government organisations, and community organisations that provide mentally healthy activities) to promote their activities under the banner of the Act-Belong-Commit message.⁷⁷

2. It was piloted in six regional communities in WA from 2005 to 2007, which subsequently demonstrated its effectiveness. Funding was therefore obtained from various sources, including the Department of Health and Mental Health Commission of the Government to expand the campaign state-wide from 2008 to 2010.

3. According to a survey in 2010, the campaign successfully changed the public's thought and attitude about mental health and mental illness, and brought about behavioural change.⁷⁸ With respect to behavioural change, 20% of those reached by the campaign reported they had done or tried to do something for

⁷⁷ Anwar-McHenry, Julia and Donovan, Robert J. and Jalleh, Geoffrey and Laws, Amberlee. 2012. Impact Evaluation of the Act-Belong-Commit Mental Health Promotion Campaign. *Journal of Public Mental Health*. 11 (4): pp. 186-194.

⁷⁸ Anwar-McHenry J, Donovan RJ, Jalleh G & Laws A (2012). Impact evaluation of the Act-Belong-Commit mental health promotion campaign. *Journal of Public Mental Health*. 11(4):186-194.

their mental health. The stated behaviours were consistent with the Act-Belong-Commit message, such as becoming more physically active/increasing exercise (31%) and socialising more/volunteering.

4. In 2014, there were 113 organisations formally signed to participate in the Act-Belong-Commit campaign. The success of the campaign has been recognised throughout Australia and internationally with uptake of the campaign by partners in Japan, London, Fiji and Denmark.⁷⁹ The campaign has entered into Phase IV (2014 – 2016) and the main objectives include to increase and maintain individuals' awareness and understanding of the things they can and should do to keep mentally healthy, to increase and reinforce participation in individual and community activities that strengthen mental health and reduce vulnerability to mental health disorders, and continue to reduce perceived stigma associated with mental health and mental illness and increasing people's openness to talking about mental health issues.⁸⁰

United Kingdom

(i) Time to Change

5. Time to Change, started in October 2007, is a charity sector-led anti-discrimination campaign for England. It is run by the leading mental health charities Mind and Rethink Mental Illness, and funded by the Department of Health, Comic Relief and the Big Lottery Fund. It had funding of £20.5 million for the first phase from October 2007 to September 2011⁸¹, and £20 million for the second phase from October 2011 to March 2015.⁸²

⁷⁹ Jalleh, G., Donovan, R.J. & Lin, C. Evaluation of the Act-Belong-Commit Mentally Healthy WA Campaign: 2014 Survey Data. School of Public Health, Faculty of Health Sciences, Curtin University, Perth, 2015.

⁸⁰ <http://www.actbelongcommit.org.au/about-us/objectives.html>

⁸¹ Time to Change website: <http://www.time-to-change.org.uk/legacy> (accessed 8 May 2015).

⁸² UK Government, press release (The government is joining forces with Comic Relief to help tackle mental health stigma, with funding of up to £20 million), 10 October 2011. <https://www.gov.uk/government/news/20-million-to-knock-down-mental-health-stigma> (accessed 8 May 2015).

6. During the first phase, the components of the campaign included advertising campaign, mass-participation exercise, community-based physical activity projects, and legal unit to pursue test cases of discrimination.⁸³ During the second phase, the components of the campaign include a national high-profile marketing and media campaign (using marketing, advertising, PR and digital communications), community activity and events, a grants scheme to fund grassroots projects, a programme to support a network of people with experience of mental health problems, a programme of media engagement to improve media reporting and representations of mental health issues, and working with children/young people and black/minority ethnic communities.

7. Since the launching of the campaign, it has reached millions of people across England. The Institute of Psychiatry of King's College London is an independent evaluation partner for the campaign in both phases. Annual surveys by face-to-face interviewing in-home have been conducted to collect people's knowledge, attitudes and intended behaviours towards people with mental health problems. The survey results showed that during 2013 there was the biggest improvement in public attitudes towards people with mental health problems in a decade, with a 2.8% improvement between the 2012 and 2013 surveys. The overall decrease in average levels of discrimination faced by people who have a diagnosed mental illness since 2008 is 5.5%. People who had seen the campaign are more likely to have better knowledge, attitudes and behaviour towards people with mental health problems than those who have not. The Campaign was adapted in Wales in 2012, under the name Time to Change Wales, led by Welsh mental health charities MIND Cymru, Gofal and Hafal.⁸⁴

(ii) Five Ways to Wellbeing

8. The UK government, under its Foresight programme, commissioned the New Economics Foundation (NEF) in 2008 to review the most up-to-date evidence and develop a set of evidence-based actions to improve personal well-being. Five actions were identified around the themes of connect, be active, take notice, keep learning and give; and were collectively named as Five Ways to Wellbeing. These five recommendations are drawing on an extensive

⁸³ Department of Health, UK (2010), 'New Horizons - Confident Communities, Brighter Futures: a framework for developing well-being

⁸⁴ <http://www.timetochangewales.org.uk/en/>

evidence base of “what works”⁸⁵. Since their launch in 2008, the Five Ways to Wellbeing messages have proven extremely popular. Groups as diverse as general practitioners, mental health commissioners, arts practitioners, church groups, community and voluntary organisations, and civil service departments have contacted NEF to discuss possible applications of the Five Ways to Wellbeing.⁸⁶ Furthermore, Foresight’s well-being agenda has been incorporated into several policy areas within mental health in UK. And in 2013, Public Health England set out a vision for the integration of well-being and health that promotes a well-being approach to public mental health through a programme of activities targeted at the public health system.⁸⁷ Internationally, these five actions have been adopted in mental health promotion activities in other countries such as New Zealand.⁸⁸

New Zealand

Like Minds, Like Mine

9. The award-winning Like Minds, Like Mine (Like Minds) programme was established in 1997 by the Ministry of Health of New Zealand. It was one of the first comprehensive national public education campaigns aimed to counter stigma and discrimination associated with mental illness. The programme is funded by the Ministry of Health and the Health Promotion Agency and is guided by the Like Minds National Plan.

10. The programme involves community activities, educational work, policy development and mass media advertising campaigns aimed at breaking down the stereotypes attached to people with experience of mental illness:

- The national media campaigns have gone through five phases since 2000. The programme has active involvement of people with experience of mental illness, e.g. The Famous People Campaign. The initial national media campaigns were to show famous people who had been affected by mental illness, and these have created significant interest, awareness

⁸⁵ Thompson S, Aked J, Marks N & Cordon C (2008). *Five Ways to Wellbeing: The Evidence*. England: New Economics Foundation.

⁸⁶ Aked, J. and Thompson, S., (2011) Five Ways to Well-being. New applications, new ways of thinking. New economics foundation

⁸⁷ Davies, S.C. Annual Report of the Chief Medical Officer 2013. Public Mental Health Priorities: Investing in the Evidence. London: Department of Health (2014)

⁸⁸ The Mental Health Foundation's pamphlet on Five Ways to Wellbeing: A Best Practice Guide. Mental Health Foundation of New Zealand.

and improved attitudes among the general public. The campaigns have shifted in emphasis over this time from focusing on famous to everyday people with mental illness, from experiences of mild or moderate mental illness to more severe ones, and from awareness raising to modelling inclusive relationships.

- Like Minds includes a Community Partnership Fund which supports projects of community partners that work towards changing social structures, cultures and policies so that social inclusion can occur more easily for those who are most excluded.
- A free phone number and a website were developed.

11. Like Minds won several awards, including Marketing Magazine's 2003 Supreme Award, and a silver award for Sustained Success in advertising at the EFFIE (Effective in Advertising) awards in 2005.

12. Like Minds has tracked public attitudes since 1997 and a total of 12 surveys have been conducted. The public attitudes surveys demonstrate that the programme improved public attitudes (3% to 7% improvement from 2010 to 2012) and behaviours (5% improvement from 2010 to 2012) towards people with mental disorders and promoted higher acceptance on people with mental disorders.⁸⁹ These mental health promotion initiatives have shown to yield economical, social and health benefits. Cost-benefit analysis showed that for every NZ dollar spent, NZ\$13.8 of benefit will be generated over a three-year period as a result of increased employment opportunities.⁹⁰

⁸⁹ Wyllie, A, & Lauder, J. (2012). Impacts of National Media Campaign to Counter Stigma and Discrimination Associated with Mental Illness. Survey 12: Response to fifth phase of campaign. Auckland: Phoenix Research.

⁹⁰ Vaithianathan, R & Pram, K. (2010). Report to Ministry of Health: *Cost benefit analysis of the New Zealand national mental health destigmatisation Programme (Like-Minds Programme)*.

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Examples of Community Projects for the Elderly with Dementia

1. Active Prevention & Early Detection of Cognitive Impairment

The Simon K Y Lee Elderly Fund (Elderly Fund) has worked with NGOs and the academia to promote early detection and early intervention through social service, research and public education. The Elderly Fund launched the Active Prevention & Early Detection of Cognitive Impairment Project (“APEC”) (先知先覺 – 認知障礙預防計劃).

APEC targeted people with mild cognitive impairment (MCI) and very mild cognitive impairment (VMCI), who suffer from reduced cognitive abilities such as memory loss, language disturbance and attention deficit. APEC aims to identify these elders in the community and provide for them early interventions so as to slow down cognitive deterioration, reduce the risk of dementia and delaying the onset.

APEC included a series of programmes include preliminary assessments, talks, street exhibitions, carer training, counselling and volunteer training etc. 8 000 elders were assessed and 650 volunteers were trained. To advocate MCI service in the welfare sector and make good use of the APEC Model, APEC also provided funding for 11 NGOs to implement the APEC Model in 44 service units in over 16 districts in the territory. About 1000 MCI and VMCI elders were engaged to undergo cognitive and physical activity intervention for one year. Besides, carer support, preliminary assessments and community education are provided.

A total of 555 elders (aged 75 on average) with mild cognitive impairments were recruited from three NGOs to join the study. Among which, 423 participants completed the study and were assessed at the 4th month, the 8th month and the 12th month since they started the activities. The results indicated an overall improvement in their cognitive functions and depressive symptoms were alleviated. 56% of the participants showed improvement in cognitive functioning, 37% maintained the same level and only 7% retrograded.

2. *The Jockey Club Charles Kao Brain Health Services*

The Hong Kong Jockey Club Charities Trust acquired Hong Kong's first brain health promotional vehicle to provide outreach support for seniors across all 18 districts through preliminary checks on memory problems under a three-year preventive programme. Under the programme, the mobile centre will provide preliminary tests for the elderly in 18 districts with a view to diagnosing early-stage dementia and offering follow-up or referral services to these elderly. Nurses and social workers will be stationed in the mobile centre for two months in each of the 18 districts, with Sham Shui Po, known for its elderly population, as its first stop.

The three-year programme comprises five components – consultation, public talks, centre-based workshops, follow-up service for patients and carers, and public education. Those who are found to have possible memory problems will be referred to government clinics, private medical practitioners and self-financing service providers. Carers will also be given dementia care tips and education kits. The Project is expected to benefit some 60 000 people.

3. **Building a Dementia-Friendly Community in Tsuen Wan**

With a view to making dementia care services more cohesive and accessible for persons with dementia and their carers, the Hong Kong Alzheimer's Disease Association has started up a district-based community shared care model for dementia in Tsuen Wan.

Funded by the Lee Hysan Foundation since April 2015, Project Sunrise seeks to enhance the readiness of the district to provide care to persons with dementia so as to allow these persons to receive care and remain in the district for as long as possible. The Hong Kong Alzheimer's Disease Association engages the public and enhances their awareness through talks and promotional campaigns, target recipients include students, family members of demented persons and frontline workers and staff at housing estates, shops, public transport, etc. The idea is to create a dementia-friendly neighbourhood and reduce stigma associated with dementia.

In addition, collaborating with the Hong Kong Medical Association, the Hong Kong Alzheimer's Disease Association provides both basic and advanced training on dementia to members of the Tsuen Wan Cluster of the Hong Kong Medical Association. The 18-hour training covers, among others, early clinical diagnosis of dementia, drug treatment, medical and community collaboration through lecture and case sharing by geriatricians and psychiatrists.

After diagnosis of dementia is confirmed by general practitioners in the community, the person with dementia can opt to receive group-based cognitive stimulation, physical and social activities under a culturally adaptive framework of Six Arts® (六藝®) at Gene Hwa Lee Centre of the Hong Kong Alzheimer's Disease Association in Tsuen Wan. Two full-day programmes per week will be provided to them according to their needs. The Lee Hysan Foundation has also been brought into play to provide subsidy for persons and families with financial needs to cover the cost of medical consultation and also programme fees.

Support, including on-going advice, guidance and advance care planning, is also provided by trained personnel (dementia care planner) to carers to empower them with knowledge and skills in taking care of their loved ones who suffer from dementia. Psychological support and counselling are also offered to reduce carers' stress.

The Lee Hysan Foundation has provided new fund to extend the Project to Kwun Tong starting from July 2016 which is being managed by the Christian Family Service Centre.

4. *Kin Chi Day Care for Dementia*

Funded by the S. K. Yee Medical Foundation, the Kin Chi Dementia Care Support Service Centre in the Western District was set up in 1999 to provide services for the elderly with dementia in the Central and Western district by St James' Settlement in partnership with the Centre on Ageing (currently named as Sau Po Centre on Ageing) of the University of Hong Kong. The sponsored project lasted for three years from 1999 to 2002. Since then, the Centre continued to operate on a self-financing basis in delivering dementia care services to families in need. In 2005, the Centre received partial funding from the Community Chest of Hong Kong to expand its service quota and scope of services.

The Centre adopts a person-centred approach to provide support services to clients with dementia including day care, in-home services to the clients and the carers. The professional team of the Centre consists of a psychologist, trained nurses and social workers. The scope of services offered includes cognitive training, psychological counseling, sensory stimulation, crisis intervention and behavioural management. Others include public health education, training for carers, volunteers and professionals.

In 2014, the second Kin Chi Dementia Care Support Service Centre was set up in Wanchai. The two centres are now serving clients and their carers in Central & Western, Wanchai and Eastern districts. The Centre has an open referral system accepting walk-in cases and professional referrals. The cases are not restricted to Hong Kong Island but include Kowloon and New Territories and outlying islands.

The demand for services for the elderly with dementia continued to rise. Currently there is a waiting list for both day care centers while the number of clients per day is maintained at the range of about 30 to 40.

5. Carers Alliance

In 2007, St James' Settlement in collaboration with Community Rehabilitation Networking and Evangelist Lutheran Church Social Services-Hong Kong established the Carers Alliance. With the administrative and office support of St. James' Settlement, the Alliance managed by a group of family caregivers, liaises with other family caregivers and organises health education and promotion in the community through partnership with local community organisations. The aim of the Alliance is to form a strong network for communication and to hold annual carers forum. More than 200 to 250 family caregivers attended the dementia caregiver forum each year discussing community support services for the dementia in Hong Kong. The participants have the chance to meet with members of the Legislative Council, representatives of SWD, psycho-geriatricians and geriatricians. The 9th Hong Kong Dementia Caregiver Forum was held in October 2015 on the theme of 'Community and 'Medical Engagement' in which forum speakers discussed the dementia related medical and social services in Hong Kong.

Since 2011, the number of community partners grew from three to more than six NGOs including Charles K. Kao Foundation for Alzheimer's Disease to hold the carers forum. Two more NGOs joined the partnership in 2013. The continuous expansion of the partnership list is a good reflection that the Carers Alliance has gained the recognition and support from NGOs. A website managed by a group of family caregiver volunteers has been developed to enhance the communication between the family carers and the public.

6. *Specialised Dementia Care Training Centre*

The Mind-Lock Memory and Cognitive Training Centre (the Centre) operated by Christian Family Service Centre had been sponsored by the Bank of China (October 2010 to September 2012) and the Keswick Foundation (October 2012 to September 2015) to provide dementia care services in the community since October 2010. The multi-disciplinary professional team, consisting of Occupational Therapist, Social Workers, Registered Nurse, in the Centre provides services to support people with complicated dementia (such as Behavioral and Psychological Symptoms of Dementia (BPSD)) and with special needs in care and training. The Centre also provides support and training to caregivers as well as staff of District Elderly Community Centres to build up their capacity in taking care of people with dementia. To strengthen medical support for the provision of dementia care services, the Centre has established close partnership with United Christian Hospital, Kowloon Hospital, Queen Elizabeth Hospital and Yung Fung Shee Psychiatric Centre in Kwun Tong to provide services for assessment, diagnosis and medical consultations to patients as well as to make referrals.

The Centre also has close collaboration with tertiary institutes such as the University of Hong Kong, the Chinese University of Hong Kong, the Hong Kong Polytechnic University, the City University of Hong Kong and the School of Professional and Continuing Education (SPACE) of the University of Hong Kong for research studies, pilot project and study for new therapy or service models (e.g. Cognitive Stimulation Therapy, Magic Cognitive Training, etc.) as well as for placement of students.

The services provided by the Centre are comprehensive to cater for different needs of the service users. The Centre provides Tailor Activity Programme and Montessori activities for BPSD management, Cognitive Stimulating Therapy for cognition, Music Therapy for mood management, community orientation training, etc. It also provides outreaching and home-based training to improve self-care functions and reduce home accidents through individual training and environmental modification. For carer support, it provides getting lost management guidelines for caregivers' reference in case their family members get lost and individual management plan to help caregivers release stress.

The Centre mainly serves Kwun Tong and Wong Tai Sin districts and provides home-based services for all districts in Hong Kong. More than 800 people received assessment services through the Centre and about 650 people received care/support services. The services provided by the Centre had been evaluated and it was found that 73% of the participants considered their conditions improved /maintained after they had received training for six months. Over 90% of the service users were satisfied with the services provided by the Centre and over 90% of the carers found stress released.

7. "Care for the Elderly - Active Mind" 『腦』有所為大行動

From 2007 to 2011, the Hong Kong Council of Social Service in collaboration with the China Light & Power Hong Kong Limited (CLP), thereafter funded by Partnership Fund for the Disadvantaged since 2010, launched the "Care for the Elderly - Active Mind" 「『腦』有所為大行動」 Programme (ACTIVE MIND). It was the largest Hong Kong community programme which brought together the Government, NGOs, the business sector, and the public to enable deprived elders with suspected cognitive impairment to go through assessment, cognitive training, and to foster greater community awareness of dementia.

Over the years, 40 NGOs with 255 centres (District Elderly Community Centres, Neighbourhood Elderly Centres, Social Centres for the Elderly, and other elderly service units) were involved. It involved almost 40% of the total elderly community service units in Hong Kong. Altogether, 603 dementia awareness promotional activities were organized with 55 362 persons participated. The potential elderly could either self-refer or be identified by others to join the ACTIVE MIND.

The Chinese version of the Mini-Mental State Examination (MMSE) was adopted as the screening tool. 15 402 MMSE were conducted territory-wide. After screening, the 5 067 suspected cognitively impaired elderly were identified to join Cognitive Training. All session materials were standardised in a "Cognitive Training Kit" 「記憶奪寶」 developed by the Hong Kong Chinese Women's Club. It was the first set of training materials specifically designed for local Chinese older persons suffering from early memory problem. The training was based on five elements: attention, registration and recall, perception, verbal fluency and problem solving ability. It aimed at improving memory, delaying decline of cognitive functions and reducing the chances of developing dementia. During the training session, participants were asked to partake in active mind games, assignments and exercises. They were also asked to complete assignments in the "trainee manual" in order to strengthen their memory and cognitive ability, and to apply skills in their daily living. An evidence based research was jointly conducted by Jockey Club Centre for Positive Ageing for the project. The study findings confirmed that after attending the Active Mind cognitive training programme, the treatment group showed better improvement in cognitive abilities and quality of life than the control group. The solid empirical evidence of the effectiveness of Active Mind program for Chinese elders in Hong Kong was confirmed. Two scientific papers were published in an international journal *Clinical Interventions in Ageing* in 2011 and 2013 respectively.

8. **“Forget Me Not” – A Community-based Memory Training Program for Person with Mild Cognitive Impairment**

The Hong Kong Chinese Women’s Club developed a memory training kit for Chinese older adults in 2006. The kit, named “Memory Treasure Hunt”® 「記憶奪寶」, was based on the five core memory elements of : Attention, Registration & Recall, Verbal Fluency, Perception and Problem Solving. In 2011 & 2013, two research reports were published in international journals to report the effectiveness of the Memory Treasure Hunt® kit. Results indicated that all cognitive subdomains (attention, initiation/perseveration, constructions, conceptualisation and memory) were improved with statistical significance. Some of the participants expressed that their short-term memory had been enhanced and found it easier to learn new skills, such as language and computer. In addition, participants reported improved mood and became happier after attending the memory training. Subsequently more elderly centres adopted the Memory Treasure Hunt kit as a major cognitive training means in their centres.

In 2015, with funding support from the Hong Kong Bank Foundation, the Hong Kong Chinese Women’s Club launched the “Forget-Me-Not – A Community-based Memory Training Program for Person with MCI”. The train-the-trainer approach was adopted, and 19 social workers from 11 elderly centres were trained to use the Memory Treasure Hunt® training kit to provide memory training to older persons with early memory impairment. Music therapy was also used as a catalyst to improve mood and memory.

588 participants were recruited in the screening and a total of 120 elders received memory training. Using paired t-test, both memory performance (Montreal Cognitive Assessment), subjective memory complaint (AMIC) and mood (Geriatric Depression Scale) showed statistically significant improvement after receiving ten sessions of Memory Treasure Hunt® training (see table below).

	MoCA score	GDS score	AMIC score
Pre-training	22.11	3.22	3.4
Post-training	23.56	2.2	2.42
t statistics	-5.127	3.981	5.972
p value	p=0.000	p=0.000	p=0.02

9. **“Reaching out Dementia Caregiver Support Project” (REACH-HK) (『腦』伴同行計劃)**

To enhance the well-being and quality of life of the dementia caregivers, Charles K. Kao Foundation for Alzheimer’s Disease Limited partnered with the Hong Kong Council of Social Service, The University of Hong Kong, and elderly service units launched the “Reaching out Dementia Caregiver Support Project” (REACH-HK) (『腦』伴同行計劃). From 2011 to 2014, funding from Charles K. Kao Foundation, together with Henderson Land Group and Partnership Fund, support the purpose of pioneering and developing dementia caregiver services in Hong Kong.

In this project, 5 078 counselling sessions for community- based families with dementia were reported. A total of 124 Registered Social Workers, from 11 agencies including 61 elderly service units, were trained for this intervention model which lasted for six months including nine face-to-face sessions (~120 minutes for each session) and three half-hour telephone sessions. 500 families including caregivers and care-recipients had been benefitted.

REACH-HK was a multi-component and the first evidence-based counselling programme for familial caregivers of dementia, which had been found to be effective for reducing caregiving burden and depression, and facilitating positive aspects of caregiving. Two documents, a localised version of “Dementia Caregiver Well-being Assessment Instrument and Multi-component Psychosocial and Behavioral Intervention Protocol” and “Practitioner Manual for Good Practice in Dementia Caregiver Services in Hong Kong” (香港腦退化症照顧者良好服務護理手冊), were produced. Three scientific papers were published in the international peer-reviewed journals, namely International Journal of Geriatric Psychiatry, Archives of Gerontology and Geriatrics, and Aging and Mental Health demonstrating the effectiveness of the program and validating the measures in the Chinese context.

It is hoped that the stress of caregivers can be further relieved through systematic assessments, counselling service, and proper techniques of taking care of the dementia patients.

10. *“Magic Cognitive Training for Dementia Elders by Youngster”* 耆青魔術
存記憶訓練計劃

With the objective to provide affordable dementia training programs, Christian Family Service Centre has started to cooperate with secondary schools since 2013. With a simple but reliable intervention mode of learning and playing magic tricks, the student volunteers were able to provide effective training to elders with dementia. Involving student volunteers as trainers not only lowered the cost of programme provision but also gave the students an opportunity to participate in voluntary services in a health-leisure pursuit.

The training content was designed by professional magician, occupational therapists and social workers. It integrated therapeutic elements in magic tricks playing, with an ultimate goal to improve or maintain cognitive functioning of the demented elderly. Students had to partake in a series of training sessions by the magician and social worker, and then started their services in the home care and day care settings. Since student trainers worked as volunteers, the training programme became very affordable to the older persons in need.

The training programme is currently provided on an ongoing basis in both day care and home care settings of the Christian Family Service Centre. An initial evaluation on 40 participants confirms that more than 70% of the participants' Mini-Mental State Examination (MMSE) score has either been improved or maintained after 12 sessions of intervention.

11. Cognitive Stimulation Therapy in Day Care Setting

Cognitive Stimulation Therapy (CST) is a structured, activity-based intervention for people with mild to moderate dementia. It is thus far the only non-pharmacological intervention recommended by the National Institute for Health and Care Excellence as an evidence-based intervention for people with dementia. Through the activities in the intervention, participants are anticipated to improve or sustain their abilities in memory, problem-solving skills, language skills, quality of life, mood, confidence, and concentration. The intervention can be conducted by professional staff or care workers, and can be applied to various settings such as day care setting, residential setting, and hospitals.

A joint study by the Hong Kong Council of Social Service and Jockey Club Centre for Positive Ageing (JCCPA) for investigating the usage pattern of day care centres for people with dementia in Hong Kong reveals that close to 50% of clients in day care centres are with dementia. Thus, there is a need to implement evidence-based activities with therapeutic benefits for people with dementia in such setting. JCCPA is one of the few self-financed dementia-specific day care centres in Hong Kong and has been adopting CST as the framework of intervention for its clients. The participants are assigned to different groups according to a number of factors such as their cognitive abilities, mobility, and preference to various kinds of activities, with an aim to help the participants to achieve therapeutic benefits and to enjoy the activities. Throughout its 15 years of operation, JCCPA has served over 2 700 people with dementia from its direct service, with a day care attendance of over 177 000.

To investigate the effectiveness of implementing CST in day care setting, a research was conducted in 2013. Assessment of cognitive functioning, quality of life of care recipients, and caregiving burden, among other parameters, was conducted at month 6 and month 12 since their admission. The cognitive functioning (measured by the Mini-mental State Examination) as well as the quality of life (measured by the Personal Wellbeing Index-Intellectual Disability) of the day care clients were maintained at month 6 and 12. In addition, the caregiving burden, measured by the Zarit Burden Interview, decreased significantly at month 12. These results affirmed the significance of implementing CST in day care setting to help enhance or maintain the cognitive and psychological wellbeing of people with dementia and thus ease the burden of caregivers.

12. Support for Family Caregivers of People with Dementia

Community-dwelling people with dementia are usually taken care of by their spouses or children / children-in-law. The caregiving usually brings burden to the caregivers whose physical and psychological health may be affected due to stress. Interventions to caregivers not only help them to maintain their wellbeing in the midst of their caregiving tasks, but also increase their competence of caregiving, and in return benefits the care recipients. JCCPA provides psycho-educational programs, caregiving and management skills programs, as well as programs for caregivers' psychological wellbeing for caregivers in the community. Apart from face-to-face caregiver support groups, it also offers telephone intervention and online psycho-educational program, with online cognitive-behavioural intervention, for the caregivers who are not able to go to the centre for in-person intervention.

The **telephone intervention** consists of 12 sessions, each session 30 minutes, one session per week. The caregivers discuss their caregiving difficulties with the interveners, and are given advice on dementia caregiving including dementia-related knowledge, communication skills, management of behavioural and psychological symptoms of dementia, caregivers' emotional issues, community resources, and long-term care plan. A single-blinded randomised controlled trial involving 38 family caregivers confirmed that participants undergoing the intervention reduced their caregiving burden significantly compared with those had not, and they also showed significantly greater efficacy in obtaining respite.

The **online website ADCarer.com** is a comprehensive website designated for family caregivers of people with dementia, it is inspired by a family caregiver e-learning program in the Netherlands, and funded by "Walk with Professor Kao" CUHK Walkathon to build up. It offers self-learned basic training on caregiving skills, training on stress reduction, grief handling, and healthy lifestyle maintenance, and an individualized online cognitive-behavioural counselling support. It has received over 5 000 000 hits. A research was conducted with 36 family caregivers who went through the online cognitive-behavioural counselling support, and found that the intervention helped significantly reduce the severity of behavioural and psychological symptoms of dementia of the care recipients, and the related distress of family caregivers. The intervention was also found particularly useful for helping caregivers of people with dementia at moderate to severe stages to control upsetting thoughts. It may be useful to support the government policy of community care and delaying the chance of institutionalisation if the caregiver is psychologically healthy.

13. "Music for Life – A Cognitive Intervention Programme with Music Therapy Elements for People with Mild Cognitive Impairment" 『美樂人生』 - 揉合音樂元素於傳統輕度認知障礙訓練計劃

Hong Kong Sheng Kung Hui Tseung Kwan O Aged Care Complex designed an innovative programme – “Music for Life” 「美樂人生」 for people with Mild Cognitive Impairment (MCI) and Mild Dementia living in the community in 2014. A “Body-Mind-Spirit” approach was adopted. Apart from focusing on cognitive domain, psychosocial, daily living function and spiritual aspects were also considered. “Music for Life” 「美樂人生」 is a cognitive intervention programme integrated with music therapy elements which was designed by a multi-disciplinary team, including occupational therapist, social worker and music therapist. The cognitive intervention programme consisted of attention, memory and cognitive training, education of memory strategies, general cognitive stimulation and compensatory cognitive rehabilitation.

To assess the effects of the cognitive intervention programme involving music therapy elements in enhancing the cognitive function, daily living function and mood in people with MCI, a research had been done in collaboration with Department of Medicine and Therapeutics of the Chinese University of Hong Kong. Results showed that subjects in the intervention group had significantly higher scores than control subjects on three cognitive measures, including the MMSE, MoCA and verbal fluency test. They also had higher score on the Lawton IADL and lower score on GDS. Changes in these measures between baseline and follow-up were also significantly different between the two groups. Specifically, the intervention group demonstrated greater improvement in these measures when compared to the control group (see table below).

Outcome measures		Mean(standard deviation)		P-value
		Control(N=17) Cognitive intervention without music	Intervention(N=16) Cognitive intervention with music	
MMSE*	Pre	24.4 (3.0)	25.0 (2.6)	0.527
	Post	24.9 (3.2)	27.9 (2.0)	0.003
MoCA*	Pre	16.0 (3.6)	18.1 (2.7)	0.064
	Post	18.9 (4.9)	23.3 (3.9)	0.008
Verbal fluency*	Pre	33.8 (8.4)	36.5 (7.6)	0.335
	Post	33.6 (8.3)	40.3 (9.2)	0.037
Lawton IADL	Pre	8 (2)	7 (2)	0.598
	Post	8 (2)	8 (0)	0.048
GDS*	Pre	4.9 (4.2)	5.1 (3.6)	0.93
	Post	5.0 (3.5)	2.2 (2.9)	0.02

People with cognitive deficits may also have different degrees of psychosocial problems, depressed mood, etc. The result of this study is encouraging that improvement shown not only in cognitive domain, but also in the areas of mood and ADL independence. Instead of focusing on cognitive training, it is worth to provide treatment in terms of “Person-centred”/ “Body-Mind-Spirit” approach, so as to fulfill the cognitive, psychosocial, and spiritual needs of people with cognitive deficits.

It is planned to explore the need of vascular cognitive impairment and adopt “Body-Mind-Spirit” approach to cognitive intervention programme with music elements in future.

14. Dementia Care Mapping and Person-centred Care Culture

Since 2009, the Hong Kong Society for the Aged had been the pioneer to introduce “Dementia Care Mapping” (DCM) of the University of Bradford, the United Kingdom, and was awarded as “Strategic Lead” of DCM in Hong Kong Region in 2010, responsible for promoting the use of DCM and advocating “Person-centred Care Culture” in Chinese communities.

Apart from training up the “DCM mappers”, the Hong Kong Society for the Aged had established a sound system for penetrating “Person-centred Care” culture in residential homes and day care centres, with the ultimate goal of improving service quality. The achievements included conducting “cultural change” training programme for staff of various ranks, doing mapping exercises per year, establishing a database of mapping results for analysis and research, and introducing a pioneer in Inter-Rater Reliability Test via Gold Standard Video. The Hong Kong Society for the Aged had shared the wisdom in the design and investment of resources in dementia services with other strategic leads in international platforms.

After completing over 3 500 hours of DCM observation, the Hong Kong Society for the Aged had achieved substantial improvements in positive and desirable interactions between staff and the elderly persons with dementia, elderly persons’ positive mood and engagement, and the quality of life of elderly persons, when comparing the results between 2010 and 2014 for nine residential homes, and between 2012 and 2014 for three day care centres.

15. Smart Use of ICT for Enhancing the Well-being of Elders

a. The Love-your-brain Website www.loveyourbrain.org.hk

The Love-your-brain Website (www.loveyourbrain.org.hk) was launched in 2007, which aimed at helping the general public to learn more about the onset of dementia and to keep aware of the elders' brain health and psychological changes. For the elders, the Website provided them with practical tips for developing healthy life habits. Stimulatory games which aimed at enhancing users' hand-eye coordination, memory, concentration, calculation and judgment with Hong Kong local features such as Mark Six and ordering Chinese dim sum are also available on the Website so as to induce the elders' interest in practicing cognitive exercise, which were specifically designed with real-life activities and provided different challenging options of which the elders could adjust the level according to their own ability. Furthermore, by browsing the Website together with other family members, family interactions and intergenerational relationships could be promoted and strengthened.

b. “Blissful Care” Community Screening & Support Services for People with Dementia & “Joyful Return” Website

Since 2010, in view of the rising service needs of the elders with dementia and their caregivers, the Hong Kong Society for the Aged introduced the “Blissful Care” Community Screening & Support Services for People with Dementia (“Blissful Care” Project). In addition to the screening assessment for the potential target group, the Project provided services which included cognitive training, caregivers training workshop and professional consultancy.

To help the carers to track down sooner the elderly with dementia who are lost, and increase public awareness of risk management, the Hong Kong Society for the Aged developed the “Joyful Return” website in December, 2014. The address www.e1668.hk, which is an easy-to-remember number in Chinese, helps to encourage the public and public transport service providers to be mindful of any wandering elderly persons and to offer timely assistance.

The “Joyful Return” website (www.e1668.hk) has been launched to provide free and practical support to caregivers regarding the prevention of missing elders with dementia. It provides prevention tips and practical strategies on preventing elders with dementia from wandering away and getting lost, and on locating them if they fail to find the way home. Through this website, caregivers are able to conduct screening test themselves, order identification accessories for their elders and prepare “Elderly Information Sheet” and missing notice in case of need.

In order to raise public concern on the potential risks that the elders with dementia may encounter when they lose their way home, the Project offers training to staff and volunteers of major public transport companies in Hong Kong. With the engagement of all community efforts, it is hoped that these missing elders can be accurately and efficiently located.

16. *“Circle Of Care” - Community Support Network for Elders with Dementia*
「智圓全」 - 認知障礙症患者社區支援計劃

Since 2009, Tung Wah Group of Hospitals - "Circle of Care - Community Support Network for Elders with Dementia" has been providing one-stop-full-spectrum services to elders with dementia and their care-givers living in Kowloon City, Yau Tsim Mong and Kwun Tong districts with a support of donation. After three years and eight months, the Project was extended through another two-year subsidy from “Partnership Fund for the Disadvantaged” and is currently operating in a self-sustaining mode.

A spectrum of services includes Community Outreach Screening, Memory Clinic, Post-Diagnosis Home-Based Care Package and Dementia Specific Day Training Centre.

Through social education and outreach screening, 5 164 cognitive assessments were conducted and 319 elders with early symptoms of dementia were arranged to attend our Memory Clinic, in which formal diagnosis, including blood tests, CT scan and clinical assessments by geriatric doctors were conducted.

To provide timely services, the “Post-Diagnosis Home-Based Care Package” was rendered to 486 families with newly diagnosed elders. By equipping family caregivers with adequate knowledge, demented elders were able to live in their own home at the onset of the illness with optimal support.

Upon receiving the home-based services, elders were rendered with day care services in our Dementia Specific Day Training Centre, where the “Physical and Mental Activated Therapy” (心身機能活性運動療法) was adopted for enhancing elders’ physical and mental functioning as a whole. In this therapeutic model, routine trainings were designed basing on elders’ physical functioning, self-competency, emotions, and social interactions, which, according to the theory of Quality of Life of Alzheimer’s Disease (QoLAD), are the 4 elements constructing their QoL.

The University of Hong Kong conducted a pilot study in 2012 (64 participants) and another randomised control-trial study in 2015 (160 participants) to evaluate the effectiveness of the Physical and Mental Activated Therapy. Both studies showed that demented elders who went through the Therapy had significant enhancement when comparing with those elders receiving traditional treatment in their cognitive functioning (MMSE), physical functioning (hand grip test, functional reach test and time-up-and-go test), mood (the Cronell Scale for Depression in Dementia) and overall Quality of Life (QoLAD).

17. “Brain Care Octopus” Community Support for the Early Dementia

The Evangelical Lutheran Church Social Service – Hong Kong was funded by the Community Chest in 2011 and launched a three-year project, *the “Brain Care Octopus” Community Support for the Early Dementia* – 「延智一站通」早期失智症社區照顧服務. The project aimed at supporting those community-dwelling elderly with mild cognitive deficits and early stage of dementia, filling the service gaps for this group of elderly and their caregivers with great stresses in daily living. Core components of the project included early screening, public advocacy, case management approach in supporting early dementia, comprehensive supports for caregivers, building volunteer network for home-based and centre-based training programs.

After three years of intensive and comprehensive interventions, the project helped 223 families, conducted memory screening test for 1 151 elderly, provided in-home cognitive training activities for 161 elderly, established “Smart Game Corner – 延智遊戲閣” at seven elderly centres, completed 327 home assessment and modifications, finished 28 Community Living Skill Training Classes (社區生活適應小組) for elderly with early dementia. In caregiver aspect, the project served 450 caregivers, organised ten caregiver training classes and 55 stress relieving workshops, and established caregiver support groups at six elderly centres.

By the end of the project, a pre-test and post-test design in comparing the MMSE scores was adopted. 46.9% of the participants showed improvements in MMSE and 20.0% of participants could maintain the MMSE score throughout the project period. As regards relieving the stress of caregivers, paired t-test was used to analyse the pre-test and post-test scores of Zarit Burden Interview. The result revealed the caregiver stress was significantly improved after joining the project.

Paired Samples Test

	Paired Differences					t	df	Sig. (2-tailed)
	Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				
				Lower	Upper			
Scores of ZBI	10.7053	14.3571	1.4730	7.7806	13.6299	7.268	94	0.000

ABBREVIATIONS

AD/HD	Attention Deficit/Hyperactivity Disorder
ADL	Activities of Daily Living
Advisory Group	Advisory Group on Mental Health Promotion
AHP	Adolescent Health Programme
AMIC	Abbreviated Memory Inventory for the Chinese
APEC	Active Prevention & Early Detection of Cognitive Impairment Project
API	Advertisement in the Public Interest
ASD	Autism Spectrum Disorders
BPSD	Behavioural and psychological symptoms of dementia
C&A Expert Group	Expert Group on Child and Adolescent Mental Health Services
Campaign	Mental Health Promotion Campaign (“Joyful@HK”)
CAMCom	Child and Adolescent Mental Health Community Support Service
CAS	Child assessment service
CCDS	Comprehensive Child Development Service
CCF	Community Care Fund
CMD	Common mental disorder
CoC	Coordinating Committee

ABBREVIATIONS (cont'd)

COC	Continuum of care
CPS	Community psychiatric services
CST	Cognitive Stimulation Therapy
CTO	Community treatment order
CGAT	Community Geriatric Assessment Team
DALY	Disability Adjusted Life Years
DCM	Dementia Care Mapping
DECC	District Elderly Community Centre
DE/DCU	Day Care Centre/Unit
Dementia Expert Group	Expert Group on Dementia
DH	Department of Health
DS	Dementia Supplement
DSQ	Development Surveillance Questionnaire
DSS	Development Surveillance Scheme
EASY	Early Assessment Service for Young People with Early Psychosis
EDB	Education Bureau
EETC	Early Education and Training Centres
EHC	Elderly Health Centre
EHS	Elderly Health Service
EP	Educational psychologist
FCPSU	Family and Child Protective Services Unit

ABBREVIATIONS (cont'd)

FHB	Food and Health Bureau
GDS	Geriatric Depression Scale
GP	General practitioner
HA	Hospital Authority
HKMA	Hong Kong Medical Association
HKMMS	Hong Kong Mental Morbidity Survey
IADL	Instrumental Activities of Daily Living
ICCMW	Integrated Community Centre for Mental Wellness
ICYSC	Integrated Children and Youth Services Centre
IFSC	Integrated Family Service Centre
IP	Integrated Programme
ISC	Integrated Services Centre
JCCPA	Jockey Club Centre for Positive Ageing
KLA	Key Learning Areas
LWB	Labour and Welfare Bureau
MCHC	Maternal and Child Health Centre
MCI	Mild cognitive impairment
MHO	Mental Health Ordinance (Cap 136)
MMSE	Mini-Mental State Examination
MoCA	Montreal Cognitive Assessment
MSSU	Medical Social Services Unit

ABBREVIATIONS (cont'd)

MSW	Medical social worker
NGO	Non-governmental organisation
PDH	Psychiatric day hospital
PPP	Public-private partnership
QoL	Quality of Life
QoLAD	Quality of Life of Alzheimer's Disease
RCHE	Residential care homes for the elderly
REACH-HK	Reaching out Dementia Caregiver Support Project
Review Committee	Review Committee on Mental Health
SCCC	Special Child Care Centres
SCNAMES	Standardised Care Need Assessment Mechanism of Elderly Services
SEN	Special educational needs
SENCO	Special educational needs coordinator
Service Framework	Service Framework on Personalised Care for Adults with Severe Mental Illness in Hong Kong
SGP	School guidance personnel
SGT	School guidance teacher
SHS	Student Health Service
SHSC	Student Health Service Centre
SME	“Sharing”, “Mind” and “Enjoyment”

ABBREVIATIONS (cont'd)

SMI	Severe mental illness
SOP	Specialist out-patient
SOPC	Specialist out-patient clinic
SPMS	Service Performance Monitoring System
SWD	Social Welfare Department
TSP	Training Subsidy Programme for Children on the Waiting List of Subvented Pre-school Rehabilitation Services
VHT	Visiting Health Team
VMCI	Very mild cognitive impairment
WHA	World Health Assembly
WHO	World Health Organization

香港成年嚴重精神病患者 個人化復康支援服務框架

Service Framework of Personalised Care for Adults with Severe Mental Illness in Hong Kong



醫院管理局
HOSPITAL
AUTHORITY



社會福利署

Social Welfare Department

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1. Introduction

Mental health services in Hong Kong are mainly supported by the Hospital Authority (HA), the Social Welfare Department (SWD), and subvented non-governmental organisations (NGOs) in the community.

HA is a statutory body managing all public hospitals in Hong Kong. The psychiatric services of HA are organised into seven clusters, each of which provides a comprehensive spectrum of care including in-patient services, ambulatory care (including specialist out-patient services and psychiatric day hospitals), and community services.

SWD and NGOs focus on the social and rehabilitation services for people with mental health problems in the community. These social and rehabilitation services aim at developing mentally ill patients' physical, mental and social capabilities to the fullest possible extent that their disabilities permit. The ultimate objective is to help them re-integrate into the community.

The needs of patients with mental illness and their families are complex, and no single agency can provide the full range of services. Moreover, mental disorders commonly run a relapsing course, with periods of remission interrupted by moments of exacerbation, and patients' needs may vary during different phases of their illness. To best meet our patients' needs, it is essential that the services provided by HA, SWD and NGOs are well coordinated and complementary to each other, so that patients and their families can receive a holistic and seamless service.

The purpose of this document is to describe an overarching service framework of how community mental health services for adult patients suffering from severe mental illness (SMI), their family and carers should be delivered. This document also delineates the roles and responsibilities of various stakeholders to efficiently deliver treatment and care. Finally, this document depicts how an integrated service is formulated based on patients' individual needs, but not dictated upon professional or organisational boundaries.

This document focuses on services provided for patients with SMI. Mental health services for more prevalent but less severe mental health illnesses, and those services provided by the private sector, are outside the scope of this document.

2. Global Perspectives on Community Mental Health Services for Severe Mental Illness (SMI)

2.1 Severe Mental Illness - a Significant Disease Burden

A mental disorder is defined as a SMI when they inflict significant extent or duration of disability and suffering to the patient. Psychotic disorders account for the majority of SMI. Psychosis affects up to 3% of the population, with onset peak at adolescence and early adulthood.¹ It is a morbid phenomenon of the brain in which the perception and thinking are dysregulated to a state that a person's contact with reality is distorted. Cardinal symptoms of psychosis include hallucination (e.g. hearing voices which do not exist), delusion (e.g. ungrounded belief of being harmed), and disorganised thought (expressed as disjointed speech or odd behaviour).

Schizophrenia is the most common type of psychotic disorders. Apart from psychotic symptoms, there are two additional dimensions in the symptomatology of schizophrenia. Negative symptoms refers to the impairment of volition, poverty of thinking, and diminished facial expression, while cognitive impairment refers to the hampering on working memory, planning, judgement, and social intelligence.

2.2 Community Mental Health Services for SMI Patients

Community mental health services refer to a network of community-based services which offer continuing treatment, accommodation, occupation and social support, and which together help people with mental health problems regain their normal social roles.² Community mental health services began to gain prominence half a century ago, when, during the 1950s and 1960s, the potentially damaging effect of institutions on their inmates was increasingly recognised.³ Deficiencies in social and life skills, known as "institution syndrome", occur after a person has spent a long period living in a mental hospital or prison. Institutions deprive people of their independence and responsibility, to the extent when they return to "outside life", they may be unable to cope. A growing body of evidence supports the notion that community, rather than institution, is the preferred setting for the recovery of mental illness. This resulted in a paradigm shift of treatment of SMI patients from institutionalisation to de-institutionalisation.

De-institutionalisation, defined as the contraction of institutional settings with a corresponding increase in community-based settings,⁴ began to take place in the United States, United Kingdom, Australia and other developed countries since the

1950s. This shift from institutionalisation to de-institutionalisation highlighted the importance of organisation and delivery of community mental health services.

In the 1970s, case management model evolved to address the problems following de-institutionalisation. A meta-analysis found that case management models were more effective than usual treatment in three outcome domains: family burden, family satisfaction with services, and cost of care.⁵ Community mental health care involves services from different providers, and a coordinating mechanism is vital if it is to be successful. The lynchpin of good coordination is the case manager. A case manager is a skilled professional who is directly concerned with all aspects of the patient's needs. Case managers work directly with the patient and his or her carers to offer a range of assessments, interventions, support and monitoring. They also arrange access to appropriate services to facilitate patient's community integration.

3. Development of Community Mental Health Services for SMI Patients in Hong Kong

Community mental health services for SMI patients are mainly provided by HA, SWD and NGOs (**Figure 1**).

Mental health service in Hong Kong was traditionally hospital-based. Territory-wide community psychiatric nursing service was implemented in Hong Kong in 1982, after a tragedy in which a mentally-ill person killed a number of people, including children in a kindergarten.⁶ Over the past three decades, the Community Psychiatric Services (CPS) of HA were provided by only a small number of Community Psychiatric Nurses (CPNs), while the majority of psychiatric nursing manpower remained in in-patient settings.⁷

Over the past six years, there has been substantial expansion in CPS of HA. In 2009, HA launched a Recovery Support Programme (RSP), a post-discharge community support programme using case management approach to cater for the vulnerable transition period of patients from in-patient to community care. The primary purpose of RSP is to provide support and care for discharged psychiatric patients and their carers through a case management model. RSP showed positive outcomes, including reduction in Accident and Emergency Departments (AEDs) attendance for psychiatric problems, unplanned readmissions, and psychiatric in-patient admissions.

In line with the global trend of moving towards the community care for patients with mental illness, HA has reviewed its service provision on CPS and has developed a new service model (**Appendix 1**) which comprises three tiers, namely the Intensive Care Team (ICT) (社區專案組), the Personalised Care Programme (PCP) (個案復康支援計劃), and Standard Community Psychiatric Services (Standard CPS) (精神科社康服務). The new service model covers a wide range of supports for psychiatric patients in need of community care. The main focus of CPS is to provide personalised care for psychiatric patients and their carers using a case management approach with a view to facilitating their community re-integration and enhancing recovery.

Apart from CPS, HA has also launched a territory-wide programme known as Early Assessment Service for Young People with Psychosis (EASY, 思覺失調服務計劃) since 2001. The purpose of this programme is for early identification and prompt treatment for people with early psychosis. EASY was initially intended for young persons aged 15 to 25 with early symptoms of psychosis. In 2011, the programme

was expanded to include all adults aged between 15 and 64 with first episode psychosis. EASY provides a comprehensive, phase-specific and intensive multi-disciplinary support for these patients in their first three critical years of illness. In addition to clinical services, public education and promotion efforts are also organised under the programme to enhance awareness of mental health in the community. EASY also provides a website and a hotline (2928 3283) for easy access.

HA has revamped its 24-hour psychiatric advisory hotline recently. The hotline, namely the Mental Health Direct (MHD: 2466 7350) is a 24-hour nurse-led hotline providing support for patients, carers and general public on issues related to mental health or mental illness.

In social welfare sector, the Hong Kong Rehabilitation Programme Plan sets out that the policy objective of the Government for the provision of community care and support services for persons with disabilities is to make available support to them according to their needs, enable them to continue living independently at home and prepare them for full integration into the community. In line with this objective, a range of social rehabilitation services for patients with SMI (including employment and vocational rehabilitation, residential care, day care and community support) have been provided with the aim of developing their physical, mental and social capabilities to the fullest possible extent that their disabilities permit.

Beginning in 2001, SWD launched a number of new initiatives to enhance the community support services for people with mental health problems. These schemes, including the Community Mental Health Intervention Project; Community Rehabilitation Day Services; Community Mental Health Link; and Community Mental Health Care Services, catered for the different stages of a patient's social rehabilitation, and sought to improve social-adjustment capabilities by helping them develop social and vocational skills, and raising public awareness of the importance of mental health. SWD has also set up a Parents/Relatives Resource Centre to provide emotional support and counselling service for the families and carers of patients with mental health problems.

In March 2009, SWD set up the first Integrated Community Centre for Mental Wellness (ICCMW) as a pilot project in Tin Shui Wai, with a view to providing one-stop and district-based community support services for discharged mental patients, persons with suspected mental health problems, their families/carers, and residents living in the district. These services range from early prevention to risk

management through casework counselling, outreaching visits, therapeutic groups, day training, occupational therapy training, supportive groups, public education programmes and, where required, direct liaison with the cluster-based CPS of HA for clinical assessment or psychiatric treatment. In October 2010, SWD revamped the community mental health support services to ICCMWs across the territory. At present, there are 24 ICCMWs operated by NGOs.

The community mental health services aforementioned, is part and partial of the overall mental services provided for patients with SMI. Other major components of the services for SMI include:

Psychiatric In-patient Care

There are 10 psychiatric in-patient units in HA. The psychiatric in-patient services aim at providing intensive in-patient care for patients who are suffering from mental disorder of a nature or degree which significantly affect their own health or safety, or with a view to the protection of other persons. For details about the admission procedures, please refer to respective sections in the Mental Health Ordinance (Cap 136).

Psychiatric Specialist Out-patient Clinics (SOPCs)

The 19 psychiatric SOPCs in HA serve as major entry points for patients newly known to the HA mental health system. HA has implemented a triage system at its psychiatric SOPCs for all new referrals to ensure patients with urgent conditions requiring early intervention are treated with priority. Under the current triage system, referrals of new patients are triaged into priority 1 (urgent), priority 2 (semi-urgent) or routine categories. HA's targets are to maintain the median waiting time for cases in priority 1 and 2 categories within two weeks and eight weeks respectively. HA has all along been able to keep the median waiting time of priority 1 and priority 2 cases within this pledge. The waiting time for new cases in non-urgent and stable condition is relatively longer as more patients are under this category. If a patient's mental condition deteriorates before the appointment, he or she could request the psychiatric SOPC concerned for re-assessment to determine whether his/her original appointment should be advanced. The patient may also consider seeking medical treatment from AED. HA will provide appropriate services accordingly.

Psychiatric Day Hospitals

HA has psychiatric day hospitals for adults in all seven clusters. Their primary objective is to allow early discharge of in-patients and to facilitate re-entry into the community. There are multi-disciplinary teams providing rehabilitation services for

patients with specific clinical needs. For example, a discharged in-patient with poor drug compliance attends a day hospital where a drug monitoring programme helps to enhance his/her drug compliance.

Residential Care Services

It is recognised that there is a need for residential service for ex-mentally ill persons who are homeless or with little family support or who need to learn to adjust to living independently in the community, as well as those chronic mental patients who do not require active medical treatment but can rehabilitate away from the hospital setting. The objective is to provide an environment with appropriate support to assist these persons to live independently in the community.⁸ The major types of residential services provided to meet the needs of ex-mentally ill persons include Long Stay Care Homes (LSCH), Halfway Houses (HWH), and Supported Hostels for Ex-mentally Ill Persons.

Vocational Rehabilitation Services

Vocational rehabilitation service aims to enable people with disabilities to secure, retain and advance in suitable employment and thereby to further their integration into society.⁸ These services include sheltered workshops, supported employment, Integrated Vocational Rehabilitation Services Centres, Integrated Vocational Training Centres, On the Job Training Programme for People with Disabilities, On the Job Training Programme for Young People with Disabilities (“The Sunnyway”).

Psychiatric Medical Social Services

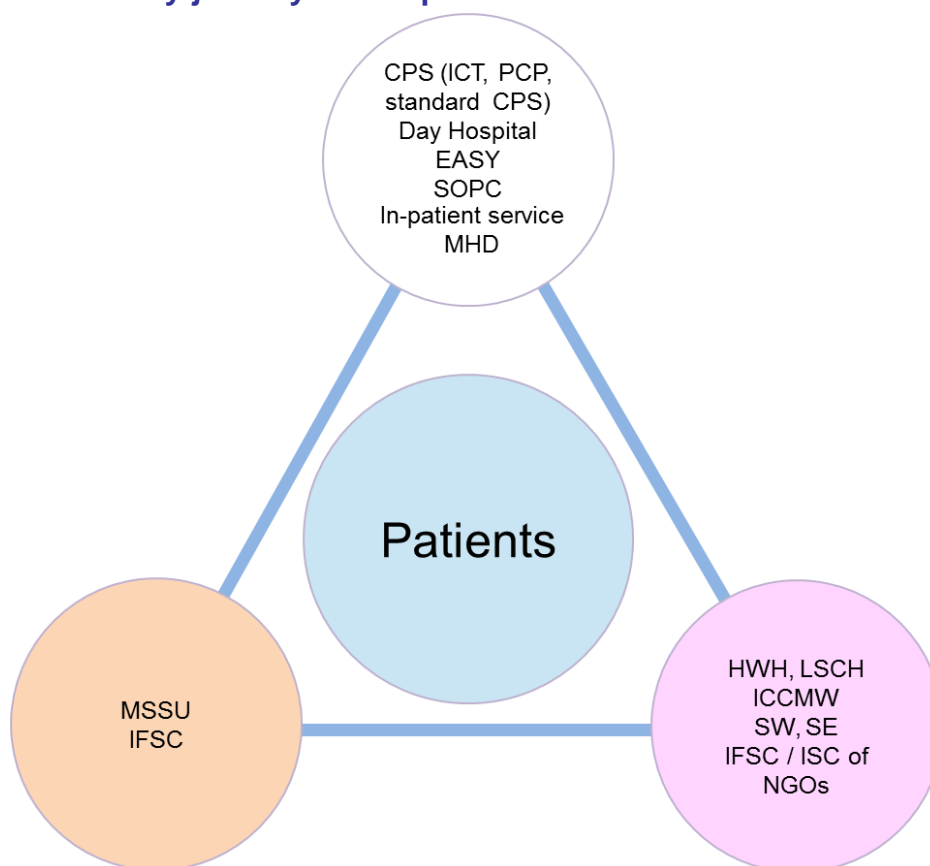
Psychiatric Medical Social Services are provided by SWD with medical social workers (MSWs) stationed in the public hospitals and psychiatric SOPCs to provide timely psycho-social intervention to mental patients and their families. MSWs being members of the clinical teams play a significant role in linking up medical and social services.

Integrated Family Service

The 65 Integrated Family Service Centres (IFSCs) and two Integrated Services Centres (ISCs), over the territory operated by SWD and NGOs, provide a spectrum of preventive, supportive and remedial services to individuals and their families in need. Services include family life education, parent-child activities, enquiry service, training in volunteering services, outreaching service, support/mutual help groups, counselling, referral service, etc. Social workers will provide appropriate services and assistance according to the circumstances and needs of the individuals and their families concerned.

Updated information on the above social services can be accessed from the SWD website: <http://www.swd.gov.hk>.

Figure 1 The major collaborating services units in HA, SWD and NGOs in the recovery journey of SMI patients



Legend:

CPS	Community Psychiatric Services
EASY	Early Assessment Service for Young People with Psychosis
HWH	Halfway House
ICT	Intensive Care Team
ICCMW	Integrated Community Centre for Mental Wellness
IFSC	Integrated Family Service Centre
ISC	Integrated Services Centre
LSCH	Long Stay Care Home
MHD	Mental Health Direct
MSSU	Medical Social Services Unit
PCP	Personalised Care Programme
SE	Supported Employment
SOPC	Specialist Out-patient Clinic
SW	Sheltered Workshop

4. Future Service Framework of Personalised Care for SMI Adults in Community

This part of the document is dedicated to describing a future model of personalised care for SMI patients in the community which has been adopted to some extent by the major stakeholders including HA, SWD and NGOs. Adopting a case management model was a milestone in the development of community mental health services in Hong Kong. Nevertheless, all achievement was only but a small step in meeting SMI patients' and their carers' needs. To succeed in this endeavour, a more comprehensive blueprint is needed to articulate the strategies through which personalised care is effectively delivered to the patients and their families, and the interventions which benefit them the most in the journey of recovery.

4.1 Affirming Our Vision, Mission and Values

Recovery is the common vision of HA, SWD and NGOs, when providing services to SMI patients in community.

Our mission, in line with the overall mental health services, is to facilitate the recovery of SMI patients by providing them and their families with personalised, holistic, timely and coordinated services that genuinely meet their medical, psychological and social needs.

The core values of recovery, as mentioned by the South London and Maudsley NHS Foundation Trust and the South West London and St George's Mental Health Trust (2010)⁹ are adopted as the basis for the Service Framework. They include:

- a) Hope – Recovery begins with hope which ignites motivation and sustains effort in the journey of recovery. Despite living with the illness, people can still have a fulfilled and meaningful life.
- b) Autonomy – Recovery means people taking control over their difficulties, the services they receive, and their lives. Through the process of empowerment as well as helping them to make choices sensibly and responsibly, they can define and pursue the meanings of their lives.
- c) Opportunity – This links recovery with social inclusion and enables people to participate in the wider society.

In this context, recovery does not limit to “clinical recovery” which is defined in terms of symptoms. It also includes “social recovery”, which is the building of a meaningful

life beyond mental illness, without necessarily eliminating all the symptoms. Indeed, social recovery is conducive to clinical recovery. High self-esteem, a sense of security, and positive emotion can lower the risk of emergence of paranoia, which is a core symptom of psychotic disorders.¹⁰ Social recovery is also a potent antidote to suicide. Life's meaninglessness, together with the enduring suffering inflicted by the mental illness, can drive patients to suicide which is the ultimate manifestation of distress, because of the illusion that death can give these despaired and exhausted people a modicum of comfort.¹¹

4.2 Effectively Delivering Personalised Care

The effective delivery of personalised care requires a number of essential components:

- a) Assessment of needs, risks and strength;
- b) Coordination and collaboration amongst major stakeholders;
- c) Quality assurance and training;
- d) Sufficient manpower;
- e) Service user involvement.

4.2.1 Assessment of Needs, Risks and Strength

A personalised care starts with a comprehensive and ongoing assessment on all the needs, risks and strength of the person. Such an assessment involves a structured clinical judgment which considers a wide array of factors unique to the person. Completing the assessment often requires cross-discipline skills and knowledge. There is a pitfall that the assessor focuses more on the aspects within one's expertise, overlooking those which are less familiar. For example, a case manager might pay more attention to the symptoms, medication adherence and side effects of medications (i.e. the bio-medical aspects), but does not adequately attend to the family dynamic and other stressors (i.e. the social aspects) which also perpetuate the illness and contribute to risks. Likewise, a case manager might heed more the social stressors and psychotic symptoms (i.e. the mental and social aspects), but overlooks the physical comorbidities which are also jeopardising the person's wellbeing. Therefore, it is worthwhile to have a standardised assessment framework which guides the disciplines providing services in HA, SWD and NGOs. (The proposed structure of the needs-risks-strength assessment, as agreed by different stakeholders, is shown in **Table 1.**)

This standardised assessment framework facilitates the completion of a comprehensive assessment of the needs, risks and strength of a person. It is not possible for case managers to fill all the items with details in one go, as priority exists among areas of needs and risks and strength, and it takes time for rapport to be established and understanding of the person to be achieved. Nevertheless, in this assessment framework, those items with inadequate information remains noticeable and systematically presented, thereby alerting the professionals to seek further information themselves or to consult another professional for more in-depth inquiry. For example, uncertainty on the item of vocational functioning prompts the case manager to listen more from the patient about his talent, interest and career aspiration, from the family about their expectation on the patient, and if necessary, from an another professional for a more detailed vocational capacity assessment. These pieces of further information are then added to the overall needs-risks-strength assessment, so that a comprehensive care plan can be completed by the case manager step-by-step, through consolidation of information from the patient, the family and other involved disciplines. This structured approach also facilitates communication among professionals of different disciplines, particularly during case hand-over. Each case manager is required to formulate an individualised care plan which details 1) the areas of needs, risks and strength; 2) personal goals; 3) intervention strategies; and 4) the parties to be involved.

The personalised assessment and care plan keeps the care delivery process focused and person-centred. Being attentive and attuned to the patient at all times, case managers can build trust and generate a strong therapeutic alliance with patients.¹² This engagement is particularly important for helping SMI patients who might otherwise refuse help.

Table 1 The structure of a needs-risks-strength assessment on a SMI patient

1. Current functioning and psychosocial stressors	<ul style="list-style-type: none">● Functioning (including self-care, vocational, and social)● Coping● Stressors and their meanings to the patient (including family relationship, inter-personal relationship, work, housing and finance, and physical ill-health)
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<p>2. Current clinical conditions</p>	<ul style="list-style-type: none"> ● Psychotic symptoms ● Other mental symptoms (including negative symptoms of schizophrenia, mood symptoms, and cognitive deficits) ● Insight, motivation and adherence to treatment ● Co-morbid substance misuse and other addiction ● Physical health ● Age and gender
<p>3. Resources, strength and values of the person</p>	<ul style="list-style-type: none"> ● Social resources (including professional services, support from family/carers, other social support network, and financial support) ● Personal strength (including resilience, talents, and hobbies) ● Personal values (including cultural and religious believes, sexual orientation, life experiences, aspiration at work and family, and meaning of life)
<p>4. Past history</p>	<ul style="list-style-type: none"> ● Self-harm or self-neglect ● Violence ● Substance misuse or other addiction ● Course of psychiatric illness (including adherence, symptoms, and frequency of relapses) ● Underlying learning disability or personality disorder ● Family history of mental illness, suicide and addiction

4.2.2 Coordination and Collaboration amongst Major Stakeholders

a) Roles and Responsibilities

Successful service delivery relies upon well-articulated roles and responsibilities of different stakeholders of community mental health services for adult SMI patients. This is of particular importance in the management of SMI patients in the community in view of the diversity of services and the number of disciplines involved. The roles and responsibilities of different stakeholders, including psychiatric doctors, nurses, occupational therapists, social workers, clinical psychologists, and primary care physicians etc, are described in **Table 2**.

Table 2 Roles and responsibilities of the major stakeholders in community mental health services for adult SMI patients

Stakeholders	Service units/ programmes	Disciplines involved	Major roles and responsibilities
Hospital Authority	<ul style="list-style-type: none"> - CPS Psychiatric SOPC - Day hospitals - EASY programme - MHD 	Psychiatric doctors	<ul style="list-style-type: none"> ● Psychiatric assessment ● Prescription of medications ● Psychological treatments ● Crisis intervention ● Mental health promotion
		Primary care physicians	<ul style="list-style-type: none"> ● Early identification of mental illness ● Management of physical health problems in SMI patients ● Mental health promotion
		Nurses, occupational therapists, social workers	<ul style="list-style-type: none"> ● Early identification of mental illness ● Psychiatric assessment ● Crisis intervention ● Psycho-social interventions ● Supporting carers ● Case management work (as case managers) ● Mental health promotion
		Clinical psychologists	<ul style="list-style-type: none"> ● Psychological interventions
Social Welfare Department	Psychiatric Medical Social Services	Social workers	<ul style="list-style-type: none"> ● Psycho-social assessment and interventions ● Statutory interventions and supervision ● Acting as appointee of mentally unfit patients to

			<p>handle their welfare money</p> <ul style="list-style-type: none"> ● Linking patients to welfare and community resources ● Coordinating or organizing educational/publicity programmes on mental health social services
Non-governmental organisations	Community support services, e.g. ICCMW	Social workers, occupational therapists, nurses	<ul style="list-style-type: none"> ● Early identification of mental illness ● Psychiatric assessment ● Psychosocial intervention ● Crisis intervention ● Goal directed training ● Supporting carers ● Coordination of care ● Psychosocial education ● Mental health promotion ● Public and psycho-education
		Clinical psychologists	<ul style="list-style-type: none"> ● Psychological assessment and interventions
	Vocational rehabilitation services, e.g. sheltered workshop	Social workers, occupational therapists	<ul style="list-style-type: none"> ● Functional and vocational assessment ● Engaging patients in vocational rehabilitation activities ● Life skill and vocational skill training ● Job matching and placement
	Residential care services, e.g. HWH, LSCH	Social workers, occupational therapists, nurses	<ul style="list-style-type: none"> ● Residential care ● Meal service ● Supervision of medication adherence ● Engaging patients in

			rehabilitation activities <ul style="list-style-type: none"> ● Life skill training ● Prepare for discharge as appropriate
Carers	--	--	<ul style="list-style-type: none"> ● Early identification of illness ● Collaboration with the helping professionals ● Supporting patients in their recovery journey

It is important to note that the service provision mentioned above is based on individual professional background and functions of different service units. The case managers, irrespective of their professional background and affiliated service units, adopt a comprehensive and holistic approach to provide a coordinated support for SMI patients in the community. The core responsibilities of a case manager under this Service Framework include:

- i) Conducting needs-risks-strength assessments;
- ii) Developing individual care plans on the basis of individual patient's needs-risks-strength profile;
- iii) Offering appropriate support and interventions to facilitate patients' recovery;
- iv) Providing appropriate support and advice to family members/carers on management of patient's mental illness;
- v) Being a point of contact and coordination;
- vi) Linking patients and family members/carers to other community resources;
- vii) Monitoring, reviewing and coordinating patient's care plan with other disciplines.

b) **Systems for Coordination**

The effective operation of community mental health services hinges upon a close partnership between the social welfare sector and the medical sector. Since 2010, formal platforms for coordination have been constructed and they were established in three levels, namely central, district and team (**Figure 2**). Building on such a background, these platforms are strengthened to enhance cross-service and cross-sectoral collaboration, develop strategies and action agenda, share case information, organise joint programmes, and handle any other issues related to mental health services.

i) Central Level

A Central Coordinating Group (CCG), co-chaired by the headquarter staff of HA and SWD, and comprising representatives of the medical and social welfare sectors, was formed in early 2010. CCG oversees the cross-sectoral collaboration among stakeholders in all domains of community services, such as the collaboration among the ICCMWs, MSSUs and the CPS.

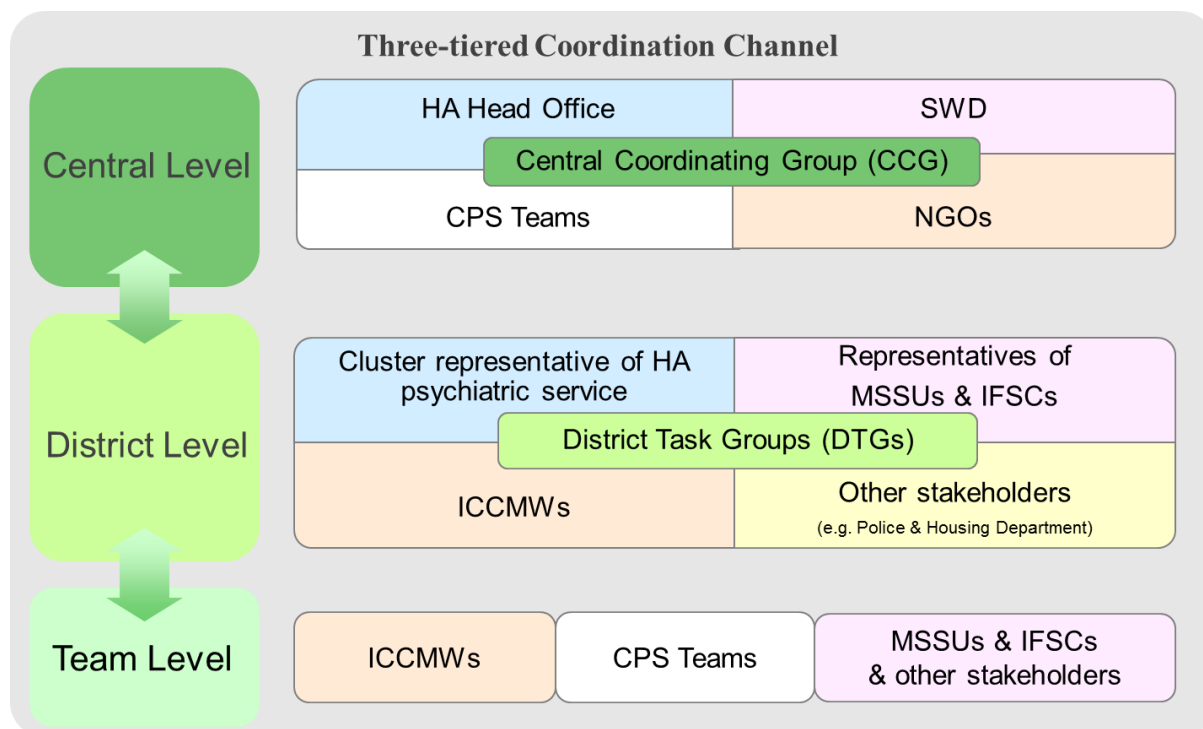
ii) District Level

District Task Groups (DTGs) were set up in the SWD's administrative districts. DTGs are co-chaired by the respective District Social Welfare Officers and the HA's cluster heads of psychiatric services, and comprise representatives of the ICCMWs, MSSUs, IFSCs/ISCs, relevant government departments such as the Hong Kong Police Force and the Housing Department, and other stakeholders concerned in the local community. Regular DTG meetings are held with a view to enhancing cross-sectoral and cross-service collaboration at a district level, and coordinating and rationalising efforts in resolving operational problems encountered, thereby facilitating effective delivery of community services having regard to district-specific demographics and service demand.

iii) Team Level

Guidelines and relevant operational issues agreed at the central and district levels will be brought forward at the team level which involves frontline staff of CPS, ICCMWs, MSSUs, IFSCs/ISCs and other stakeholders as appropriate (**Appendix 2**). At this level, case conferences are also conducted regularly for discussion of selected SMI patients. Direct case referrals through telephone contact and escort services for psychiatric consultation could also be arranged. For patients with highly complex needs, shared case management involving HA, SWD and NGOs can be provided.

Figure 2 Three levels of coordination amongst major service providers



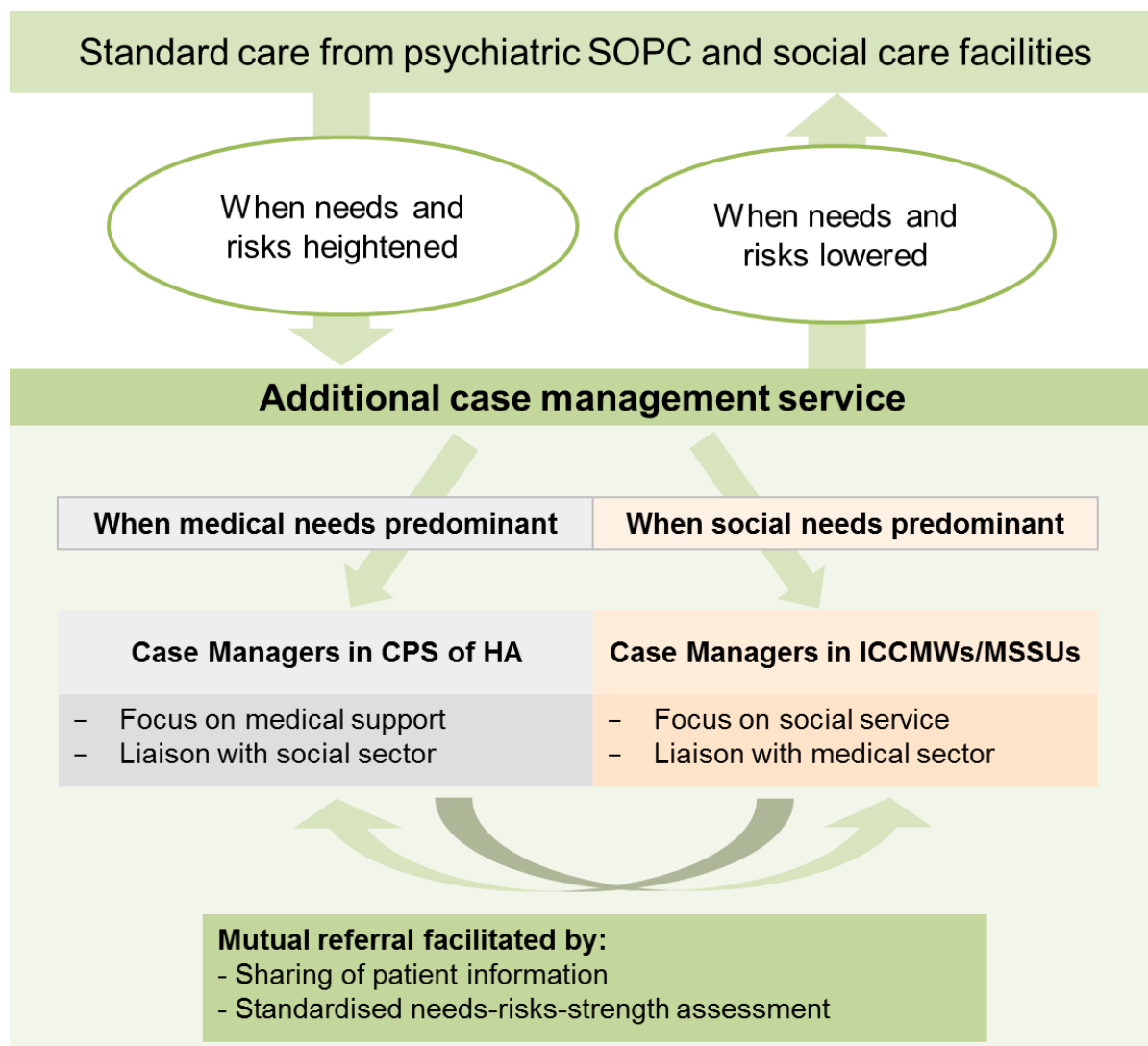
c) System of Access and Transit

ICCMWs are district-based centres in close connection with the neighbourhood. By virtue of their ease of accessibility, ICCMWs are often the first point of contact in the community and means of collaboration with other community partners such as the Housing Department and the Police. Through working with these partners, ICCMWs can engage with those SMI patients whose untreated illnesses have caused concern in neighbours or the community by large. The collaboration will also help ICCMWs to identify SMI patients who lack insight to their illness and unaware of their need for psychiatric treatment. In urgent situations, ICCMWs/MSSUs and CPS will conduct crisis intervention together to arrange involuntary admissions into psychiatric hospitals for SMI patients who are at risk of harming themselves or others. In such situation, MSWs may be involved in handling the emergency and invoke legal provisions as appropriate.

In the recovery journey, ICCMWs, MSSUs and other welfare service units closely collaborate with CPS under a case management model. According to a patient’s needs-risks-strength profile, an appropriate level of care in medical and social sectors could be determined. The transit of patients between the medical and social sectors aims at matching the needs and risks of the person with the expertise of the helping professional and the required facilities. In general, a patient with predominant

medical needs will have a case manager from the medical sector (CPS of HA), whereas a patient with more stable mental condition and requiring mainly social rehabilitation services will be under the care of a case manager from the social sector (mainly social workers of ICCMWs or MSWs) (**Figure 3**). Nevertheless, in all phases of recovery, there is much collaboration between the medical and social sectors, as no single agency can meet all the bio-psycho-social needs of a person, and the most important role of a case manager is to function as a care coordinator who links the patient with the most appropriate services from all possible sources. For example, apart from the support of the case manager, a patient might receive interventions from a psychiatric MSW or a social worker in a welfare service unit for family and childcare issues. Meanwhile, the patient also receives treatments for physical comorbidities from doctors and allied health professionals of other specialties, and attends vocational rehabilitations from NGOs. The case manager coordinates all these services by ongoing assessment of the patient's needs, risks and strength, as well as facilitating communication among all the involved professionals and the patients' families.

Figure 3 Coordination between CPS and ICCMW / MSSU in provision of case management service



d) Information Sharing

To further enhance the communication amongst service providers in both the medical and social sectors, it is essential to tackle the impasse regarding on one hand fulfilling the Personal Data (Privacy) Ordinance (PD(P)O) (Cap. 486) and on the other hand facilitating communication to ensure safety and wellness of individual SMI patients. Although PD(P)O contains exemption clauses on grounds of health and protection of others, mental health professionals frequently find it challenging to handle the situation to help those who are in need but refuse services.

Recently, progress has been made on streamlining the practice of patient data transfer among the Police, HA and SWD. Nevertheless, we need a more robust infrastructure for communication among the agencies providing health care or social services. The clinical and social conditions of patients might change abruptly, and the interplay between clinical and social issues is usually complex. Timely and holistic support, through coordinated interventions from various agencies, is necessary along the whole recovery journey. Therefore, effective communication is crucial for both the health care sector and social sector to be functionally integrated into a unified health-social care body which are sensitive and responsive to all the needs and risks of patients.

In practice, prescribed consent for personal data transfer should be obtained from the person, upon the first contact with social workers or health care professionals. The collection, retention and transfer of data must adhere to the data protection principles in PD(P)O. All the access to personal information shall be logged, and can only be done on a need-to-know basis.

e) Other Areas of Collaboration

The collaboration between the medical and social sectors extends beyond direct patient services. They also work together in mental health promotion which is an integral part of the community mental health services. A regular event of collaboration is the Mental Health Month programme held annually. The Programme is a territory-wide mental health promotion campaign led by the Labour and Welfare Bureau. It is supported by HA, SWD, NGOs and other stakeholders of the community. It aims at raising public awareness on mental health and combating the stigma against mental illness. CPS and ICCMW empower front-line staff of key community partners, such as the Housing Department and the Police, with knowledge on mental health, to help them with their everyday work.

Case examples illustrating how patients benefit from the collaboration of different

stakeholders are included in **Appendix 3** as reference.

4.2.3 Quality Assurance and Training

To ensure continuous quality improvement and evaluate service delivery, robust governance systems are paramount for both the medical and social sectors.

Within HA, the Coordinating Committee (CoC) in Psychiatry is accountable for setting standards and overseeing the quality of CPS. The CPS Working Group reports to the CoC (Psychiatry) and is responsible for the implementation of CPS across clusters, including service development, coordination, and monitoring. Each cluster CPS unit is accountable for the quality of service, and a consultant psychiatrist is also appointed to lead the CPS team at cluster level.

SWD and NGOs jointly established the Service Performance Monitoring System (SPMS) stage by stage from 1999 to 2002. SPMS ensures accountability on the use of public funds and the provision of quality social welfare services. The service performance of NGOs is assessed based on:

- a) Annual reporting on self-assessment of Essential Service Requirements, Service Quality Standards (SQSs), Output Standards and Outcome Standards (OSs/OCs) by service operators on their service units' performance with, if applicable, specific action plan on non-compliant area(s);
- b) Self-reporting by service operators half-yearly on variance in the performance of OSs/OCs;
- c) Review visits/surprise visits to selected service units for each service operator at least once in three years; and
- d) On-site assessment of new service units and other units with identified/suspected problem areas in service performance.

The entry professional qualification requirement and other rank-specific requirements for case managers in HA are clearly specified and closely adhered to the "Clinical Standards for Adult Community Psychiatric Services". In addition, each case manager has to complete a six-month case-management training programme which encompasses lectures, workshops, case sharing, and clinical practicum.

The professional staff within the social sector include registered social workers, qualified nurses (psychiatry), physiotherapists, occupational therapists, etc. The entry qualifications, relevant experiences, and other specific requirements are adhered according to the staffing requirements stipulated by SWD. Each NGO has

own human resources management to provide staff supervision and training. Staff also receive on-the-job training over specific areas including guardianship, domestic violence, marital counselling, family therapy, child protection and etc.

The purpose of case management is to facilitate recovery. Case managers should be equipped with expertise in a number of evidence-based psychiatric interventions to meet the recovery needs of patients. This includes interventions such as medication management, motivational interviewing, cognitive behaviour therapy for psychotic symptoms, family intervention and vocational rehabilitation. Effective applications of all these therapeutic interventions require not only skills and knowledge, but also a correct attitude on recovery. A local survey revealed a significant need for staff training on recovery, particularly on the understanding of the non-linear trajectory of recovery and the importance of consumer choice. When patient care plans are individualised, training on staff should also be tailored, according to their knowledge, concerns, and experience with patients. A mix of experiential and didactic approach, with involvement of service users, can be adopted in such training. Indeed, recovery training for all stakeholders is essential to ensure that our mental healthcare is recovery-oriented.¹³

4.2.4 Sufficient Manpower

Caseloads are an important service parameter because there is a limit to the number of patients whom can be looked after effectively at any one time. In CPS of HA, the number of cases handled by each case manager varies and the caseload is determined by a number of factors including the complexity of patients being supported and the experience of individual case managers. The workload of each case manager is regularly reviewed by each cluster where supervisors will ensure that the workload is distributed appropriately among case managers. On average, each case manager will take care of about 40-60 patients with SMI at any one time. HA will regularly review the service capacity of its CPS to ensure emerging service need is timely met.

Staffing requirements of ICCMWs include social workers, psychiatric nurses and occupational therapists. ICCMWs have the flexibility to deploy the subvention under the Lump Sum Grant Subvention System to arrange suitable staffing and number of the respective professionals to meet service needs of individual centres. It is notable that apart from SMI patients, service users of ICCMWs also include patients with common mental disorders, those with emotional distress and persons suspected to have mental problems. Depending on the service needs of the serving district

and the work focus of individual ICCMW, the number of cases handled by social workers of ICCMWs varies. The average caseload of a social worker in ICCMWs is around 40-50. Apart from these casework loads, social workers in ICCMWs are also required to provide other services, including therapeutic/supportive groups and programmes, outreaching visits, public education, networking activities, etc.

To effectively deliver care using a case management model for SMI patients in Hong Kong, it is necessary to regularly review the caseload and manpower arrangement in teams. Such reviews should take into account of the local context, including clinical (e.g. prevalence of different psychiatric morbidities), socio-economic (e.g. demographic structures and household income), cultural (e.g. attitude to mental illness and treatment) and geographical (e.g. population density) factors and the healthcare system. Nevertheless, reference can be made to our overseas counterparts, when we look for caseload which has been empirically shown to be appropriate, and team structures which are cost-effective.¹⁴ In the United States, a survey on agencies providing mental health-targeted case management services found an average caseload of 1:29 per case manager. In the Netherlands, a Flexible Assertive Community Treatment (FACT) team serves approximately 200 SMI patients in a region; at any one time, 20% of these patients require assertive outreach and intensive support. The caseload of a case manager in a FACT team is 1:25. In the United Kingdom (UK), a community mental health team had an average caseload of 1:21, with 55% suffering from SMI. In UK, there are also Assertive Community Treatment (ACT) teams providing highly intensive care to SMI patients, with a very low caseload (no more than 1:15).¹⁵ However, recent evidence suggests that the low caseload and specified ACT staffing had no effect on outcome and ordinary community mental health teams in UK appear to deliver equal outcomes with much reduced resources.¹⁶

4.2.5 Service User Involvement

Peer support workers, who are service users doing well in their recovery, can be employed in the service teams and play an important role in helping SMI patients to achieve their recovery goals. There is evidence on the positive impact of peer support workers teaching illness management.¹⁷ Pilot schemes of peer support workers have been launched in CPS and some ICCMWs, HWHs and vocational rehabilitation units, and the results are satisfactory.¹⁸ SWD has also launched a 2-year pilot project on peer support service in community rehabilitation units in 2016, and the results will be reviewed.

Besides peer support workers, service users are also involved in giving feedback to services as stipulated in the Service Quality Standards of SWD and implemented at various community services. Furthermore, as part of the Implementation Task Force of the “Mental Health Service Plan for Adults (2010 – 2015)” of HA, a new user group consists of nominated representatives from service users and carer groups, and relevant NGOs is formed to collect their feedback and opinions to enhance service planning. In some NGOs, apart from providing service feedback, there are user-operated programmes.

4.3 Areas of Unmet Needs

In the case management model, the case manager is the key person who oversees the implementation of a holistic care plan of the patient. Nevertheless, there are still many bio-psycho-social needs of patients which a case manager cannot solely handle. There are a number of priority areas of unmet needs which should be addressed by the medical services, social services and community by large.

4.3.1 Vocational Rehabilitation

Employment is an effective means to improve the quality of life and levels of social inclusion for patients with SMI.¹⁹ Patients are more satisfied if they have paid work, compared with no work or volunteer work. Supported employment is an evidence-based intervention to enhance the vocation outcomes for SMI patients. Individual Placement and Support (IPS) is a well-researched supported employment approach, which is effective in helping patients with SMI to achieve competitive employment.²⁰ IPS offers active assistance for vulnerable people to find and keep paid work. In Hong Kong, a randomised controlled trial reported that IPS was more effective than the conventional vocational rehabilitation programme in helping individuals with long-term mental illness to find and sustain competitive employment.²¹ In Hong Kong, supported employment is mostly provided by NGOs and the availability of job opportunities in the private sectors is still limited. The availability of supported employment can be increased through establishment of social enterprises by NGOs, giving due recognition to good employers, sharing good practices and providing incentive and assistance to employers, etc. Negotiation with the Government, private enterprises and NGOs should be continued.

4.3.2 Physical Health of SMI Patients

Patients with schizophrenia have a two-fold increased risk of premature death from medical causes compared to the general population.²² Cardiovascular diseases are the leading cause of death in patients with schizophrenia.²³ SMI heightens risk of metabolic syndrome which includes diabetes, obesity, dyslipidaemia, and hypertension. A local study found that 35% of SMI patients in community have metabolic syndrome; 27% are smokers, and 62% lack physical exercise.²⁴ Metabolic syndrome, together with smoking and lack of exercise, are key risk factors for cardiovascular disease.

As SMI patients are at increased risk of metabolic syndrome, their health consciousness and awareness about their physical health should be heightened. Health education, exercise programmes, dietary counselling, and smoking cessation should be provided at the primary care as health improvement packages for all SMI patients.

Sports teams and other physical exercise groups have been organised by ICCMWs, and the feedbacks are encouraging. Programmes on physical exercise and healthy lifestyle can be strengthened in community service units which promote mental health. Access to services by primary care physicians, dieticians and physiotherapists should also be enhanced.

HA has launched a monitoring programme for those SMI patients on second generation antipsychotic, aiming at early identification of metabolic syndrome. This programme is an early step in addressing the inequality in physical health for SMI patients. The next step should be effective interventions for those identified at risk of cardiovascular diseases.

The co-existence of SMI and physical ill health poses a particular challenge in management. Apart from strengthening resources in all the involved disciplines, cross-discipline training and collaboration is also required. It is desirable for case managers to be equipped with knowledge and skills in physical health interventions. Primary care physicians and psychiatrists should have closer collaboration and exchange of expertise.

4.3.3 Supporting Carers and Children of SMI Patients

The burden on family members and carers of SMI patients are huge. They bear

mixture of emotions and are under great stress in coping with the challenges in handling family members' illnesses. Children of SMI patients, in particular are under even bigger negative impacts of their parents' illness. Schizophrenia is a heritable disorder and the risk of schizophrenia in a person with one or both parents suffering from the disease is about 15% and 30% respectively, while the risk in general population is only 1%. Apart from their genetic vulnerability, these children may have traumatised by experience of their parent's relapse of illness; having mentally-ill parents seriously dents their self-esteem. Parenting difficulty may lead to poor parent-child relationship and distress which increase the risk of relapse in the patients, and risk of illness in their children.

The welfare of the children and the support for carers of SMI patients need to be enhanced in order to provide a continuum of preventive, supportive and remedial services for them in the community. The support should be able to reach out and proactively attend to the needs of the children and families/carers of SMI patients who often fail to voice out their needs. There is a need to expand intervention focus from individual-based to family-based. A system perspective should be taken; we have to improve care coordination between mental health and social service professionals as well as other involved professionals and community partners in the education sector and legal sector. The effectiveness of these interventions should be evaluated. For example, in CPS of HA, a mental health promotion programme for children with mentally ill parents has shown positive impacts on the children, especially in the domains of self-efficacy, self-esteem, interpersonal relationship and reducing anxiety.²⁵

4.3.4 Combating Stigma and Discrimination on Mental Illness

Stigmatisation and discrimination on mental illness is widespread,²⁶ and that might be even more severe within Chinese communities.²⁷ Hong Kong is still trailing in the battle against stigma and discrimination on mental illness. Oppositions from local residents are often received during the consultation process for the proposed premises for mental rehabilitation facilities.

Stigma prevents people with mental illness from seeking treatment.²⁸ Societal understanding and response might determine the prognosis of SMI, independent of the effect of treatment.²⁹ Public education is therefore important and should therefore be conducted as a long-term campaign to enhance public knowledge and awareness on mental health issues. The public should also be conveyed the important message that recovery of SMI requires social inclusion, and discrimination

against SMI patients is one of the major obstacles to their recovery.

Improving the chance of recovery is indeed an important way of tackling stigma and discrimination against a disease. For example, tuberculosis had been highly stigmatised about a hundred years ago. With the advent of much more effective antibiotic treatment, the outcome of tuberculosis, and subsequently the stigma and discrimination, have markedly improved. The recent expansion and reform in the community services for SMI patients in Hong Kong is expected to improve the recovery of SMI, thereby lowering the stigma. Thus, the above-mentioned service improvements are indeed integral parts of the battle against stigma and discrimination.

5. Conclusion

The disease burden of SMI is huge, and if poorly managed, SMI inflicts tremendous and lasting disability and suffering on both patients and their families. Community mental health services are important for patients with SMI, as the community is by far the preferred setting of treatment and rehabilitation. Inadequate and poorly-organised care in the community could drive discharged SMI patients back to institutions rather than towards recovery.

The needs of SMI patients are complex and vary along the course of illness. Personalised and sustained services in medical, psychological and social domains are necessary. Recovery-oriented case management model has been proven to be an effective approach to support SMI patients towards recovery. The challenge lies in the coordination of services to provide holistic and person-centred treatment for patients, and the availability of resources that could ensure accessibility of effective treatments to all in need.

In Hong Kong, service providers including HA, SWD and NGOs have been endeavouring, albeit under constrained circumstances, to deliver the best possible community services for SMI patients. Apart from services provided by case managers, there is also multidisciplinary care provided by doctors, nurses, social workers, clinical psychologists, occupational therapists and other allied health professionals. In addition, there are also residential care and training opportunities provided for rehabilitation.

Upholding recovery as the vision and adopting a case management approach in service delivery are the impressive strides in community mental health services in Hong Kong. The Service Framework depicted in this document serves to provide the foundation of collaboration among stakeholders in a way that services are based on individual SMI patients' needs, but not professional or organisational boundaries. This document hopes to act as the first step to initiate the deliberations of the wider society in rallying and channelling much needed resources, care and support to this disadvantaged group.

To put this service framework into action, the next step is to draw an action plan which would include:

- a) Implementation of a standardised needs-risks-strength assessment framework: This assessment framework should be used by professionals in both the medical and social sectors.

- b) Development of operational guidelines: The guidelines, which govern the collaboration among service providers in the medical and social sectors, must be robust enough to promptly link patients to the most appropriate services, overcoming professional and organisational boundaries.
- c) Exploration of establishing an effective mechanism for timely information sharing among HA, SWD and NGOs: For each SMI patient under this Service Framework, all the involved professionals can readily know the contact means of the case manager, the patient's most updated needs-risks-strength profile and care plan, and the services being provided. Up-to-date and comprehensive information is the prerequisite for timely, holistic and person-centred interventions.
- d) Staff training: Each case manager in CPS of HA or ICCMW/MSSU should undergo a training programme on needs-risks-strength assessment, care planning and other core skills of delivering intensive case management to patients with SMI in the community.
- e) Planning on manpower: To meet the emerging service needs of patients with SMI, careful consideration has to be taken to work out an appropriate caseload for case managers in both medical and social sectors. Within each agency, the size, structure and staff-mix of teams should also be evaluated, so that manpower is utilised cost-effectively. Regular review is essential to ensure the provision of quality services.

The success of this endeavour is not just determined by the practitioners in mental health care. Catering for the full spectrum of needs and alleviating the plight of the SMI patients definitely calls for concerted efforts of all sectors of the community. With experience gained after implementation of the action items listed above, this Service Framework will be reviewed in three to five years' time.

6. Appendices

Appendix 1

Community Psychiatric Services of the Hospital Authority

Objectives

The Community Psychiatric Services (CPS) of HA is committed to providing recovery-oriented care for mentally ill persons in the community with a primary focus on SMI. It also endeavours to promote mental health in community.

Sources of referral

- ➔ General / private practitioners of Hong Kong
- ➔ Hospital Authority (HA)
 - Accident and Emergency Departments (AEDs)
 - Specialist Out-patient clinics
 - Psychiatric out-patient clinics (e.g. general adult psychiatric clinics, child and adolescent psychiatric clinics, EASY clinics, Comprehensive Child Development Service clinics, substance abuse clinics, etc.)
 - In-patient units of psychiatric hospitals
 - Mental Health Direct (MHD)
 - Consultation-liaison service
- ➔ Other community stakeholders (e.g. Integrated Community Centre for Mental Wellness (ICCMWs), family members, carers, etc.)
- ➔ Government and other organisations (e.g. Housing Authority, Police, School, Social Welfare Department (SWD), District Council, etc.)
- ➔ Non-Governmental Organisations (NGOs) (e.g. Church, The Suicide Prevention Centre, The Samaritan Befrienders HK, etc.)

Service structure

CPS of HA has adopted a three-tiered multi-disciplinary case management model, with close collaboration with community partners.

(a) Three-tiered stratification of patients

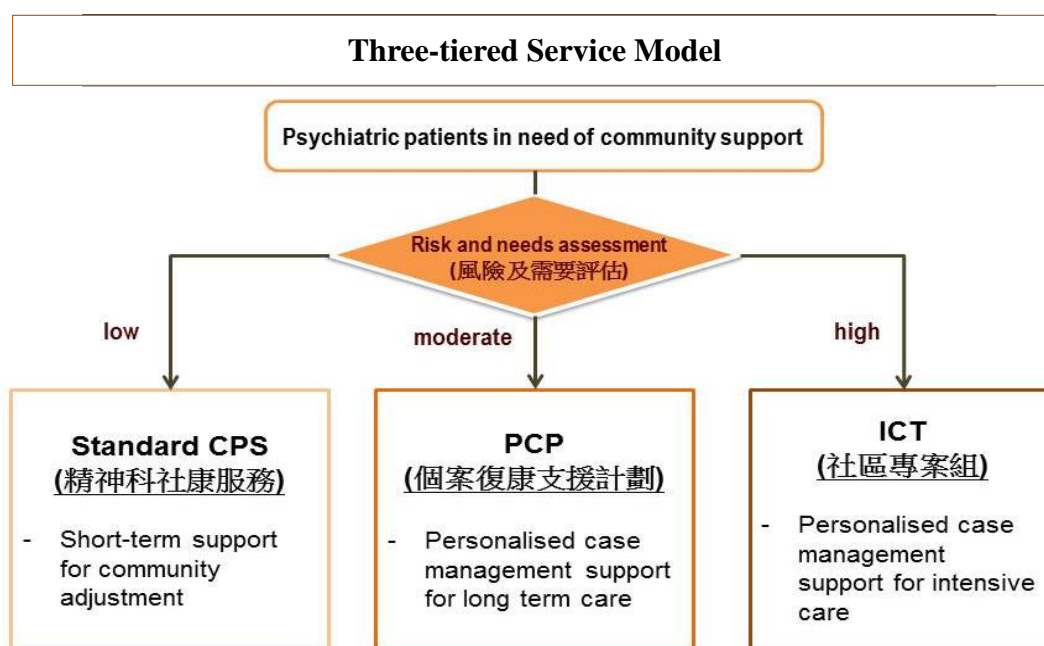
Patients are stratified into three tiers by structured clinical judgement. This judgement is based on their risk and needs profiles which are compiled from detailed and on-going assessments on a number of areas:

- i) Significant past history, e.g. self-harm, violence, substance abuse, traumatic experience, personality and illness episodes etc.

- ii) Current clinical conditions, e.g. mental symptoms, insight to the illness, functional status, personal distress
- iii) Current life events and social stressors, e.g. unemployment, marital discord, debts, and bereavement etc.
- iv) Current resources and personal strengths, e.g. housing and financial condition, family support, social network, and resilience in personality etc.

Each tier is provided with a specified service package, namely the Intensive Care Team (ICT, 社區專案組) for the first tier, the Personalised Care Programme (PCP, 個案復康支援計劃) for the second tier, and Standard Community Psychiatric Services (Standard CPS, 精神科社康服務) for the third tier. The figure below illustrates the three-tiered service model of CPS.

Figure 1 Three-tiered service model of the CPS



The risk level of a patient may change from time to time during the course of illness. Therefore, on-going risk and needs assessments are conducted to determine the most appropriate level of care or intervention in a particular period of time or stage of illness. The caseload of an individual case manager would be based on the patients' risks and needs profiles which are also matched with the case manager's expertise. This is regularly reviewed in clusters' team meeting where supervisors will adjust where necessary and ensure cases are distributed appropriately among case managers.

First-tier: Intensive Care Team (ICT, 社區專案組)

Patients in the first tier are those with a very high risk of violence, suicide, or self-neglect, or with a high level of clinical complexity. The majority are acutely mentally ill or in relapse of a severe mental illness. Patients receiving 'Intensive Care' under the Special Care System (SCS) belong to the first tier. Patients under 'Conditional Discharge' of the Mental Health Ordinance, together with a history of non-adherence to treatment, are also placed in the first tier. No age limit is set for referral. The ICT provides intensive support for this group of patients. The team will provide appropriate intensive community care including crisis intervention and assertive community outreach. The response time to service requests for this group of patients should be within 24 hours.

An example of the clinical profile and level of care in the First-tier of CPS

Profile of needs and risks	Level of care
<p>a. Current stressful life events and ongoing social stressors; poor functioning, e.g. poor self-care, unemployment, impending divorce, financial difficulty due to substance abuse.</p> <p>b. Unstable current clinical conditions, e.g. persistent psychotic symptoms with much personal distress, active substance abuse and pre-contemplation stage of change, lack of insight to the illness, poor medication adherence and poor motivation in rehabilitation, poor physical health complicating psychiatric treatment, refusal of services.</p> <p>c. Lack of resources and personal strengths, e.g. homelessness, absence of family support or social network, and lack of adaptive coping.</p> <p>d. Numerous risk factors from the past history, e.g. serious self-harm and violence upon relapse, poly-substance abuse, psychopathy in personality,</p>	<p>Services by the Intensive Care Team (ICT), including:</p> <ul style="list-style-type: none"> - Assertive engagement with the patient - Contact once to twice per week - Frequent review of care plan and risk assessment - Close monitoring of mental condition and supervision on medication adherence - Monitoring of physical health condition - Medication management programme - Motivational interviewing for substance abuse - Warning to the potential victim of the patient's aggression - Crisis intervention, with preparation for hospital admission - Support on coping with psycho-social stressors - Linking the patient with welfare and other tangible support

frequent relapses due to poor medication adherence.	- Engagement in rehabilitation, exploring personal recovery goals
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Second-tier: the Personalised Care Programme (PCP, 個案復康支援計劃)

The second tier refers to a group of psychiatric patients with frequent relapses and poor drug compliance, or those with significant psychosocial problems and emotional difficulties. The majority suffer from SMI. Patients receiving ‘Special Care’ under the SCS also belong to the second tier. The target patients for the PCP are adults aged between 18 and 64 residing in the districts covered by the PCP team. The PCP team provides long-term recovery-oriented support to this group of patients. The response time to service requests for this group should be within three working days.

An example of the clinical profile and level of care in the Second-tier of the CPS

Profile of needs and risks	Level of care
<p>a. Ongoing social stressors, impaired functioning, e.g. long-term marital discord, high expressed emotion in family, financial stress due to poor budgeting, dropping off from rehabilitation programmes.</p> <p>b. Relatively stable clinical conditions but vulnerable to relapse, e.g. remission of psychotic symptoms but inadequate insight to the illness, irregular compliance to maintenance antipsychotic treatment, suboptimal physical health status.</p> <p>c. Limited resources and personal strengths, e.g. inadequate family support or small social network, prone to maladaptive coping upon major stressors.</p> <p>d. Some risk factors from the past history, e.g. few episodes self-harm and violence upon relapse, extended period of abstinence from illicit drugs, low</p>	<p>Services by the Personalised Care Programme (PCP), including:</p> <ul style="list-style-type: none"> - Contact once to twice per month - Regular review of care plan - Alert vs relapse upon life events - Monitoring of medication adherence, medication management programme - Monitoring of physical health condition, facilitating lifestyle modification - Facilitate progress in rehabilitation, e.g. aiming at supported employment, exploring personal recovery goals - Counselling and support on psychosocial stressors - Enhance support network - Family intervention on expressed emotion in family - Encourage participation in recreational and social activities in an ICCMW, enhancing self-esteem and

self-esteem and pessimism in personality.	establishing supportive social network - Development of adaptive coping
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Third-tier: Standard Community Psychiatric Services (Standard CPS, 精神科社康服務)

Patients in the third tier are those with relatively stable mental conditions but still in need of community support to maintain their mental stability and optimise their functional capability in the community, and where appropriate interventions may prevent unnecessary hospital admissions and facilitate community re-integration. The Standard CPS team provides support for this group of patients. The response time to service requests for this group should be within five working days.

An example of the clinical profile and level of care in the Third-tier of the CPS

Profile of needs and risks	Level of care
a. Some social stressors, but residual functional deficits, e.g. childcare burden, work stress; impaired vocational functioning. b. Stable clinical conditions e.g. remission of psychotic symptoms and good medication adherence. c. Some resources and personal strengths, e.g. having family support and social network, resilience in personality but lack of self confidence due to illness experience. d. Few risk factors from the past history, e.g. no serious self-harm and violence upon relapses.	Services by Standard CPS, including: <ul style="list-style-type: none"> - Facilitating progress in rehabilitation, e.g. aiming at open employment - Enhance stress management - Participation in recreational and social activities in an ICCMW; expanding social network and developing a healthy lifestyle - Support in the pursuit of personal recovery goals

(b) Multi-disciplinary Team Approach

To provide holistic support to patients in the community, the service has introduced a multi-disciplinary approach with the role of case manager taken up by nurses,

occupational therapists and registered social workers, depending on the needs of the patient. Together with risks-and-needs stratification, the expertise of the assigned case manager can be matched with the patient's unique condition. As CPS is an integral part of general adult psychiatric service in the HA, psychiatric doctors in the general adult psychiatric service have close collaboration with case managers, both in clinical rounds and outreach visits.

(c) Clinical Case Management Model

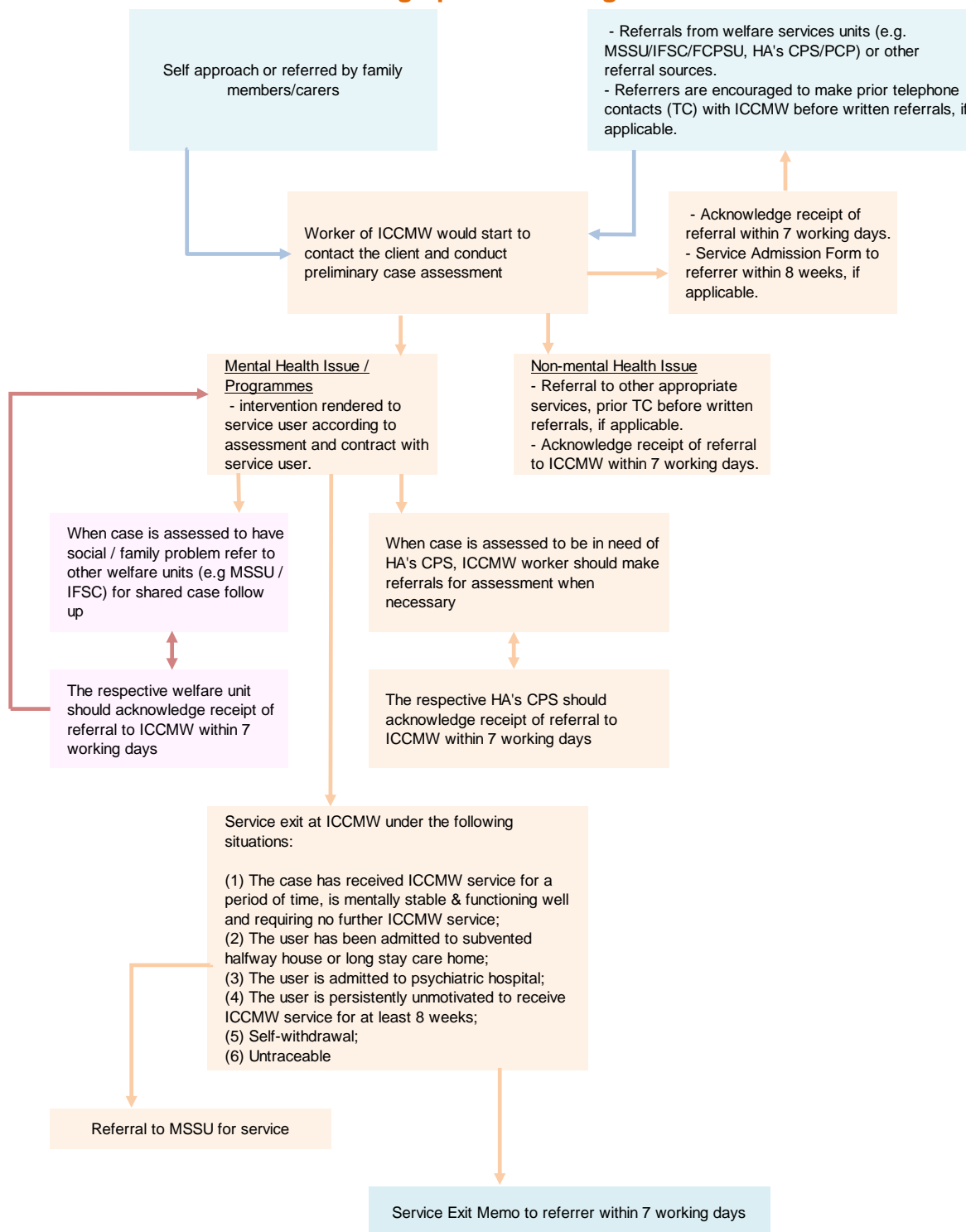
In this clinical case management model, each case manager is required to formulate an individualised case plan in collaboration with the patient and carers. The patients' strength and their personal recovery goals are essential components in care planning, alongside the risks and needs factors. As patients make progress in their recovery and the clinical and social condition changes with time, the care plan is subject to regular review. By detailing the areas of needs, the intervention strategies, parties to be involved, and the agreed intervention goals, the individualised care plans allow the care delivery process to be more focused and bespoke. Validated assessment tools are also used to measure outcomes including symptoms, functioning, quality of life, carer stress and patient satisfaction.

(d) Collaboration with Community Partners

Platforms have been established both at the central and district level for communication with SWD, NGOs, the Police Force and the Housing Department (Section 4 of this document). CPS of HA has been working closely with ICCMWs, which are district-based centres run by NGOs, in the early identification and intervention of those in need of mental health service, as well as supporting the patient's journey of recovery in the community. There are agreed collaboration guidelines between HA and ICCMWs for the management of SMI in the community. Some degree of shared care for individual patients may exist while in the transition period between HA and ICCMWs. For example, if a patient is referred from the CPS to ICCMW, the degree of support from CPS will be gradually faded out if the patient becomes more adapted to the support offered by ICCMW.

Appendix 2

Workflow of Integrated Community Centre for Mental Wellness (ICCMW) on Case Handling upon Receiving New Referrals



(Abstracted from “Collaboration Guidelines among Integrated Community Centres for Mental Wellness, Psychiatric Service and Personalised Care Programme of the Hospital Authority, Medical Social Services Units and Other Welfare Services Units”)

Appendix 3

Case Examples of Collaboration among the Hospital Authority (HA), Social Welfare Department (SWD) and Non-governmental Organisations (NGOs) in Provision of Community Mental Health Services

Case 1

Madam Wong was a middle-aged housewife, living with her husband and two teenage sons in a public housing unit. She had no prior contact to mental health service. About one year ago, she started to delude that her neighbours were harming her by putting poison into the drinking water. She sensed a bad odour her family members could not feel at all. She repeatedly lodged complaints against her neighbours to the Housing Department. Subsequently, she took revenge on them by making noise at home every night. The Housing Department sought help from an Integrated Community Centre for Mental Wellness (ICCMW). One week later, a social worker from the ICCMW, together with an officer from the Housing Department, made a home visit to Madam Wong. Madam Wong strongly denied being mentally ill. She agreed to be helped by a social worker, as she felt being troubled by a number of social problems in which the “harassment” by the neighbour was the most threatening. The ICCMW social worker engaged Madam Wong by exploring her distress which also included the conflict with her husband, who was a gambler, and with her sons, who was indulged in video game after school. Madam Wong was less distressed after being listened and supported by the ICCMW social worker who arranged her two sons to attend a youth centre after school, and referred her husband to a counselling service on pathological gambling.

As the clinical manifestations are suggestive of a psychotic disorder, the social worker of the ICCMW referred this patient to the Community Psychiatric Services (CPS). A joint home visit by the ICCMW social worker and a case manager of CPS was conducted. Madam Wong was eventually persuaded to attend a psychiatric SOPC; she acknowledged that her mood was disturbed and her sleep was poor, although she denied having delusion. The ICCMW social worker and the CPS case manager accompanied her to attend the first appointment in the Specialised Out-patient Clinic (SOPC). Madam Wong was diagnosed with schizophrenia. Oral antipsychotic medications were prescribed. Madam Wong was in the acute phase of her psychotic illness, and monitoring of her delusion and medication compliances were the major areas of needs; therefore, she would benefit the most from the interventions from a case manager who was a Community Psychiatric Nurse (CPN) in the CPS. The outreach service by ICCMW ceased. The CPS case manager accompanied

Madam Wong to attend the subsequent follow-ups in the SOPC. Half a year later, Madam Wong had her persecutory delusion subsided, and she was adherent to the psychiatric medications. With psycho-education by the case manager she gained insight to the mental illness, and she accepted the need of maintenance antipsychotic treatment and stress management to prevent relapse. The case manager also provided family intervention from which her husband and sons learned how to communicate with Madam Wong, and to identify early signs of relapse. Madam Wong had interest in cookery, and she took the most pleasure from making meals for her husband and sons. She attended a cookery class in ICCMW. She made some new friends there. An expanded social network and improvement in cooking skills improved her self-esteem and sense of well-being. Despite taking maintenance antipsychotic medications, Madam Wong has achieved recovery in which she regained control on her life and found meaning from it; she was able to perform well in her chosen roles, namely mother of her sons and wife of her husband.

Case 2

Mr. Chan was an unemployed man in his early twenties. He was unmarried, living with his parents and siblings in a public housing unit. He had no prior contact to mental health services. He had been unemployed for three years, as he was losing volition to work. Two years ago, he started to hear non-existing voices and believed that he was being gossiped and followed by ex-colleagues. He felt his thought being known to others via a device implanted into his brain. These experiences were so distressing that he had thought of suicide. He expressed the plan of hanging himself. His parents called the hotline of the Early Assessment Service for Young People with Psychosis (EASY). In view of the imminent risk of self-harm, a crisis intervention was provided by two CPNs of the EASY team in the next day. Mr. Chan was compulsorily admitted to a mental hospital for treatment. The diagnosis was paranoid schizophrenia. He was discharged home after three months of in-patient psychiatric treatment. He attended out-patient treatment in a SOPC of the EASY team. His case manager who was an occupational therapist engaged him in rehabilitation training in a day hospital. After three months in the day hospital, his self-care ability, work volition and social skills were enhanced. His relationship with his parents improved, as he managed better self-care. His parents, upon family intervention, understood that his functional and cognitive impairment was due to his mental illness; they became less critical to him, and encouraged him to attend rehabilitation training.

Mr. Chan resumed gathering with some friends with whom he had lost contact since the onset of his mental illness. The case manager referred him to a NGO for

supported employment of a cleaning job in a sports ground. Mr. Chan chose this job, as he had more interest in outdoor work and he was proud of his strong physique. Upon the encouragement of his case manager, he also joined the running team of an ICCMW, and participated in other recreational activities in ICCMW. One year later, Mr. Chan remained mentally stable, and had his insight to mental illness and medication adherence consolidated. However, he was still in need of further support in his vocational rehabilitation. After discussion among Mr. Chan, his parents, the case manager in the EASY team and the social worker in ICCMW, it was agreed that the case manager role was to be passed to the ICCMW social worker. After receiving service from EASY for three years and being mentally stable, Mr. Chan was transferred to receive outpatient treatment in a SOPC of the General Adult Psychiatric Service of the hospital. After two years of support employment, Mr. Chan progressed to open employment, getting a cleaning job in a private housing estate. A few years later, he had a mild relapse of schizophrenia, precipitated by bereavement in family; the case manager in ICCMW contacted CPS for a joint outreach visit. Mr. Chan was admitted voluntarily to a mental hospital for two weeks. He was visited by his friends in the hospital. This episode of relapse subsided soon after adjustment of medications and bereavement counselling. After discharge, he resumed his cleaning job in the private housing estate.

Case 3

Mr. Tam was a 17-year-old Form 6 student. He had no prior contact to mental health services. He became mentally unwell two years ago; he became suspicious against classmates and teachers. He also heard non-existing voices which spoke out his thoughts and made derogatory comment on him. He failed to concentrate on his studies and his academic performance was declining. He was so afraid of being harmed by others that he did not attend school. He was idling at home, and his personal hygiene was deteriorating. His parents were badly frustrated, especially when they failed to persuade him to consult a doctor. His school social worker's persuasion was also in vain, as he strongly denied being mentally ill. His school social worker sought help, via email, from EASY of HA. With his parents' consent, a case manager of EASY and the school social worker made a joint home visit. He agreed to speak to them, because he acknowledged having social problems rather than mental ones. They listened to his stress which came from his studies and failed courtship. As he felt being understood and supported, he was willing to disclose the details of his persecutory belief and the hallucinatory experience. Eventually, he agreed to consult a psychiatrist, and he was offered an appointment in a SOPC of EASY. He attended the SOPC with the company of the case manager and the school social worker. He was diagnosed with schizophrenia and was prescribed an

antipsychotic. The case manager provided him with psycho-education and medication management training. Subsequently, his insight to his mental illness and medication adherence was improving. Through family intervention by the case manager, the communication between Mr. TAM and his parents improved. His parents had their self-blame resolved, and accepted their son's need of rehabilitation. Mr. Tam attended a day hospital where he had training on activity of daily living and social skills. His delusion and hallucination subsided, after antipsychotic treatment and relief of mental stress. Three months later, he resumed schooling. In weekends, he attended a stress management class and the soccer team of an ICCMW in his housing estate. He mastered skills in stress coping, and he was aware of impact of stress on the risk of relapse. He knew some new friends in the soccer team. Soccer games also made him physically fitter. He became less shy when meeting people. His self-confidence was enhanced, despite the experience of schizophrenia.

7. Abbreviations

AED	Accident and Emergency Department
CCG	Central Coordinating Group
COC	Coordinating Committee
CPN	Community Psychiatric Nurse
CPS	Community Psychiatric Services
DTG	District Task Group
EASY	Early Assessment Service for Young People with Psychosis
FACT	Flexible Assertive Community Treatment
HA	Hospital Authority
HWH	Halfway House
ICCMW	Integrated Community Centre for Mental Wellness
ICT	Intensive Care Team
IFSC	Integrated Family Service Centre
IPS	Individual Placement and Support
ISC	Integrated Services Centre
LSCH	Long Stay Care Home
MHD	Mental Health Direct
MSSU	Medical Social Services Unit
MSW	Medical Social Worker
NGO	Non-Governmental Organisation
OS/OC	Output Standard and Outcome Standard
PCP	Personalised Care Programme
PD(P)O	Personal Data (Privacy) Ordinance
RSP	Recovery Support Programme
SCS	Special Care System
SMI	Severe Mental Illness
SOPC	Specialist Out-patient Clinic
SPMS	Service Performance Monitoring System
SQS	Service Quality Standard
SWD	Social Welfare Department

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